Leicestershire Partnership NHS Trust

Seclusion and Long Term Segregation Policy

Providing staff within Leicestershire Partnerships NHS Trust with clear direction and process for the use of seclusion and long term segregation in adults and children.

Key Words:	*Seclusion, Restrictive Practice, Long-term Segregation, Isolation, confinement, low stimulus.*	
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Type of Policy ***(tick appropriate box)***	Clinical ✓	Non Clinical
Which Relevant CQC Fundamental Standards?	9,10	

Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
2015 review, version 1	May 2015	Extensively revised in response to the publication of the Mental Health Act Code of Practice 2015.
2015 review, version 2	June 2015	Revised following comments made by members of the Seclusion Group at its meeting of 4th June 2015. Amendments made to reflect the NICE guidance 'Violence and aggression: short-term management in mental health, health and community settings' (2015)
2015 review, version 3	July 2015	Revised following comments made about version 2. Title changed to Seclusion and Restrictive Practices Policy Procedure for the use of the extra care facility within the CMHS inpatient unit added
2015 review, version 4	August 2015	Revised following comments made about version 3. Revised following comments made by members of the Seclusion Group at its meeting of 31st July 2015. Addition of training pack and competence assessment tools
2015 review, version 5	September 2015	Revised following comments made by members of the Seclusion Group at its meeting of 8th September 2015. Addition of competence assessment tools with criteria to meet Addition of Seclusion Review Record Sheet
2016 review, version 6	November 2016	Reviewed following comments from CQC Mental Health Act visit and meeting with FYPC clinical leads and AMH Head of Nursing in consultation with Director of Nursing. Inclusion of text relevant to children and young people under 18. Addition to review standards with particular reference to isolated or stand-alone units.
2016 review, version 7	November 2016	Removal of the procedure for nursing in a separate area, and other revisions made following comments from members of the Seclusion Group.

Version 8 and 9	2018	Updated to reflect least restrictive practice and Positive and safe work.
Version 10 and 11	May 2019	Revised policy with new documentation for seclusion following improvement cycle. Revised layout of forms.
Version 12	September 2019	Revised forms following improvement cycle. Amended nursing reviews for seclusion and long term segregation and reflected in policy document.
Version 13	July 2020	Revision of forms, amendment to timings for independent review for clarity, correction of approved clinician throughout document amendments to use of seclusion whilst patient requires long term segregation.
Version 14	September 2020	Slight amendments to record forms and change to role and responsibility of the Clinical Duty Manager.

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Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that **due regard** for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and services are free from discrimination;
- LPT complies with current equality legislation;
- Due regard is given to equality in decision making and subsequent processes;
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy.

Definitions that apply to this Policy

Advance statement	An advance statement is a way for a user of mental health or learning disability services to say how he or she would like to be treated in the future if they ever lost the ability to decide for themselves.
Approved clinician	A professional approved by the Secretary of State or a person or body exercising the approval function of the Secretary of State to act as an approved clinician for the purposes of the Mental Health Act. All responsible clinicians must be approved clinicians.
CAMHS	Child and Adolescent Mental Health Services
Direct observation	Entry into the seclusion room for reviews and to assess the physical and mental state of the patient to determine whether the seclusion should be terminated or to offer food and fluids. No staff should ever enter the seclusion room alone, or be left alone, with a patient in seclusion. There must be a minimum of three appropriately trained staff available for direct observations.
Extra care area	An extra care area is defined as a quiet, low-stimulus space for patients experiencing high levels of arousal during periods of disturbed behaviour and can be used for de-escalation, patient support and management and treatment in a bespoke space for high intensity intervention. (PICU National Minimum Standards, 2014). The area may be used before or after seclusion to support de-escalation.
IMHA	Independent Mental Health Advocate
Indirect observation	Observation through the locked seclusion room door, window, other viewing window or CCTV display to ascertain the safety of the patient and observe behaviour.
Continuous Level of observation	The patient must be in sight of the nurse at all times but not necessarily at arm's length. The nurse needs to be close enough to the patient to enable effective intervention at any time if required. The patient must be in sight of the nurse (via direct or indirect observation methods) at all times by day and by night and any tools or instruments that could be used to harm self or others must be removed.
Long-term segregation	Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a patient is not allowed to mix freely with other patients on the ward/unit on a long term basis. In such cases, it should have been determined that the

	risk to others is not subject to amelioration by a short period of seclusion combined with any other form of treatment; the clinical judgement is that if the patient were allowed to mix freely in the general ward environment, other patients or staff would almost continuously be open to potentially serious injury or harm. (MHA Code of Practice, 2015).
MAPA	Management of Actual or Potential Aggression (Training to give staff skills to manage people in crisis when the risk of aggression is increasing and physical interventions to manage the actual risk of aggression at a last resort)
Multi-disciplinary team	For the purposes of this policy, appropriate membership of the multi-disciplinary team (MDT) should include the responsible clinician (or another ward doctor), a ward nurse, and staff from other disciplines as relevant. At weekends and overnight, membership of the MDT may be limited to medical (for example, on-call doctor) and nursing staff, in which case the unit/ area coordinator should also be involved in clinical decision making.
Positive behavioural support	A framework that seeks to understand the meaning of behaviour in order to inform the development of supportive environments and skills that can enhance a person's quality of life. This can reduce behaviours that challenge and lead to a reduction in the use of restrictive interventions.
Prevention and Management of Aggression (PMA)	Umbrella-term which covers a range of training to prevent and manage violence and aggression and the Health & Safety aspects of aggression. Training includes conflict resolution, Strategies for Crisis Intervention & Prevention (SCiP), Management of Actual or Potential Aggression (MAPA) and Dementia Capable Care.
Restrictive Practice	"…are a wide range of activities, some deliberate and some less so, which restrict people. Restrictive interventions lie within this and are a range of specific interventions." *A positive & proactive workforce, Skills for Care. April 2014*
Restrictive Interventions	"Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: - take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; - end or reduce significantly the danger to the person or others; - contain or limit the person's freedom for no longer is necessary"

	• **Physical Restraint-** 'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.' • **Mechanical Restraint- '**the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.' • **Chemical Restraint-** 'The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.' • **Seclusion-** 'The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving.' 'Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others.' *Positive and Proactive Care: Reducing the need for restrictive interventions, DoH. April 2014*
Rapid tranquilisation	The use of injectable medication to control severe mental and behavioural disturbance, including aggression associated with mental illness.
Seclusion	Seclusion is the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where all other options have been explored for the purpose of containing severe behavioural disturbance which is likely to cause severe harm to others. Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed for the purposes of seclusion and which serve no other function on the ward. (MHA Code of Practice, 2015).

1.0. Purpose of the Policy

1.1 The purpose of this policy is to provide all Trust staff with an understanding of the process and safeguards for patients when using restrictive interventions and the expectation that the use of seclusion or long term segregation will be the last resort.

1.2 This policy has been developed in accordance with the NICE Clinical Guideline, 'Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments' and in line with the Mental Health Act 2015 Code of Practice and Positive and Proactive Care: reducing the need for restrictive interventions, Department of Health, 2014.

1.3 The Policy considers equality and diversity issues for all patients with particular emphasis on vulnerable equality groups especially from the black and minority ethnic (BME), lesbian, gay, bi-sexual and transgender (LGBT) and learning disability communities, staff, visiting carers, and fellow professionals.

1.4 Restrictive interventions will only be used by Trust staff where all verbal de-escalation, medication, distraction and other talking therapy has failed. During the use of any restrictive intervention attempts to verbally deescalate and stop any restrictive intervention must be used continually.

1.5 People who use services are only cared for in seclusion if it is:

- The last option to maintain the safety of the patient or others at a high risk of harm.
- Should only be used for those detained under the Mental Health Act. If there is an emergency situation requiring seclusion for an informal patient a Mental Health Act assessment for an emergency detention should take place immediately.
- Although falling with the definition of medical treatment, seclusion is not a treatment technique. The use of seclusion cannot typically be foreseen. However, if patients have indicated a preference for seclusion instead of restraint, or if there are associated medical risks with restraint such as positional asphyxia identified, consideration of a service user advanced directive agreed with the MDT should take place.

1.6 It is important that the Human Rights of the Individual are upheld and that all patients should be treated with dignity and respect and that equality and diversity issues are maintained.

1.7 Where a young person under the age of 18 is admitted to an adult ward, the safeguards outlined in MHA Code of practice (1983) chapter 19 must be adhered to. Clinical advice from senior clinicians within the CAMHS service must be sought.

1.8 Mental Health Service For Older Persons (MHSOP) have adopted dementia capable care which is focus on de-escalation and lower level of MAPA technique due to the frailty of the patient group and using least restrictive interventions. MHSOP do not have seclusion facilities, in exceptional circumstances where the

risk is too high collaboration with AMH colleagues will be sought to access wider resources which might include seclusion.

1.9 Whenever possible the multi disciplinary team will anticipate, identify and record the potential for disturbed or aggressive behaviour when care planning. Alternative and preventive measures such as early identification 'de-escalation strategies', Positive Behaviour Support and the provision of constructive activity and exercise will be included within the care plan. Where there is an increased risk of violence and corresponding likelihood of physical restraint, a care plan indicating the most appropriate physical interventions must be developed as a guide to staff and where appropriate make reference to the need for increased observation and engagement.

2.0. Summary and Key Points

2.1 The policy aims to:

- Ensure the physical and emotional safety and wellbeing of patients
- To support and offer guidance to staff in managing behaviour that challenges, and violence and aggression from patients in a least restrictive way
- To ensure that for any restrictive intervention patients and staff receive necessary care and support during and after the intervention
- Ensure that patients receive the necessary care and support both during their seclusion or long term segregation and after it has taken place
- Designate a suitable environment that takes account of the patient's dignity and physical wellbeing
- Set out the roles and responsibilities of staff, and set requirements for recording, monitoring and reviewing the use of seclusion and any other restrictive practice, including any follow up action.

3.0. Introduction

3.1 The policy applies to all Mental Health and Learning Disability areas. It is widely known that within Inpatient Services there will be times where de-escalation will fail and to maintain safety staff will have no option than to use restrictive practice.

3.2 In line with the latest Department of Health guidance, (Positive and Proactive care: reducing the need for restrictive practice, 2014) and NICE guidance, NG10; Violence and aggression: short-term management in mental health, health and community settings, 2015, the Trust is working towards reducing restrictive practice.

3.3 This policy serves as support for staff and guidance for staff in the use of seclusion and long term segregation and what should happen afterwards.

3.4 Trust staff will focus primarily on providing a positive and therapeutic culture, which aims at preventing behavioural disturbances through positive behavioural support, early recognition and de-escalation.

3.5 The Trust and its staff acknowledge the majority of our patients are not violent or aggressive. However, for some patients when they are unwell the risk of violence or

aggression can be increased and staff need to be confident and skilled in minimising the impact of such behaviour on the patient, other patients and staff. Therefore the Trust and its staff will work together with patients to minimise the use of restrictive interventions as seclusion and physical restraint can be very distressing for patients and their families.

3.6 De-escalation will be the first response to any episode of and engaging patients in meaningful activity, only where these have failed and alternative strategies have not been successful will consideration be given to the use of restrictive interventions or as a very last option, seclusion. The use of any restrictive intervention, including seclusion must be safe, reasonable and justifiable in order that it minimises distress to the individual and strives to maintain dignity. Its use must only be in order to preserve safety and enable a reduction in risk to others.

3.7 Every effort must be made to ensure that a patient's dignity, physical, emotional, cultural and spiritual needs are met throughout any restrictive intervention and certainly during the period of seclusion. There must be no unlawful discriminations.

3.8 Where there is potential or an increased likelihood of the use of any restrictive intervention, staff must consider the patient's wishes and preferences with a view to minimising any trauma or negative consequences of their use. Staff must use care planning and Advanced Statements as a way of sharing these with the MDT and involving patients in their care.

3.9 Staff must be aware of the potentially harmful psychological consequences of restrictive interventions and specifically Seclusion and long term segregation within this policy, notably feelings of:

- increased despair and isolation
- anger and confusion
- worsening of delusions and hallucinations, and the effects of sensory deprivation
- fear and trauma
- worsening/heightened anxiety

3.10 It is essential that patients receive the necessary care and support both during and after the use of seclusion or long term segregation. An explanation should be provided as sensitively as possible to carers or relatives on what is happening to the patient and the rationale of any restrictive intervention. All communication and relationships must promote individual respect and dignity, support equality and diversity, and ensure clear exchange of information.

3.11 At the earliest opportunity following the termination of seclusion, the patient must be given the opportunity to carry out a debrief and discuss the incident with the most appropriate member of their clinical team. The discussion should detail the patient's perception of what happened and why, consider future strategies in the event of a similar situation (through the use of an advance statement or care plan) and record any complaints that the patient may have and act on them accordingly.

3.12 Staff must also be involved in reflection following the incident in order to learn from the patient and the event, and understand how the environment and antecedents may have contributed towards the aggression. This feedback should inform patient care plans and wider service quality improvement work. This can be addressed in reflective practice sessions or supervision and would encourage the attendance of the MDT.

3.13 Consideration must be given to others who witness the incident and support should be offered accordingly. Support and guidance on this can be found in the Safewards model intervention titled 'Reassurance'.

4.0. Duties within the Organisation

4.1 The **Trust Board** has a legal responsibility for Trust policies and for ensuring that they are carried out effectively. The Trust will ensure that seclusion and long term segregation activity is regularly monitored and audited. Reports will be provided to local management teams, appropriate Governance Groups, the Patient Safety Group from the Positive and Safe Group.

4.2 The **Positive and Safe Group** has the responsibility for reviewing this Policy. The group will request reports on the implementation of the policy, and commission Trust-wide audits on the use, frequency and duration of any restrictive practice, be that seclusion or other forms of restraint on an annual basis the approval of the policy is by the Trust Patient Safety Improvement Group.

4.3 The **Divisional Director** and **Heads of Nursing** are responsible for disseminating the policy and ensuring that all staff work to achieve policy standards. **Local management teams** are responsible for monitoring the use of restrictive interventions via their Governance Groups and completing reports as requested.

4.4 The **Ward Sister / Charge Nurses and their deputies** have the following responsibilities:

- To ensure that all staff are suitably trained and up to date in the use of seclusion, segregation, de-escalation and Prevention and Management of Aggression (PMA) skills, and work to achieve policy standards and have completed the relevant competency.
- To ensure staff are fulfilling their responsibilities and where staff are found to be breaching this, the Trust will manage this through the performance and conduct management procedures.
- To ensure that an eIRF is produced following each use of seclusion or segregation.
- To ensure that seclusion or long term segregation records are accurately maintained and the information is produced as requested by managers.
- To review practice in their area on a monthly basis to monitor policy compliance and report on this to the Positive and Safe Group.
- To address any discrepancies or issues for practice identified during monthly review, and report immediately to the operational manager or matron.

- To undertake a quality check to assure the accuracy of MDT documentation for each seclusion episode.
- To put systems in place to check the physical environment in the seclusion room and ensure that it is fit and ready for the next use.

4.5 The **Matrons (or Team Manager if Matron not available)** have the following responsibilities:

- To ensure that seclusion is being used appropriately within their area of responsibility.
- To ensure that quality check has been completed by Ward Sister/Charge Nurse.
- To identify any themes or trends regarding seclusion.
- To provide oversight and support for seclusion and segregation within their area of responsibility.

4.6 The **Responsible clinician and duty doctor** are expected to regularly review the patient in seclusion and take part in multidisciplinary discussions.

- If seclusion is not authorised by a psychiatrist, **there must be a medical review within one hour or without delay.**
- Continuing medical reviews **every four hours (this requirement includes evenings and weekends etc.)** until the first internal Multi-disciplinary team review
- Following first (internal) multi-disciplinary team continuing medical **reviews at least twice daily** (one by the responsible clinician)

- **Medical reviews** provide the opportunity to evaluate and amend seclusion care plans, as appropriate They should be carried out in person and should include, where appropriate:
  - a review of the patient's physical and psychiatric health
  - an assessment of adverse effects of medication
  - a review of the observations required
  - a reassessment of medication prescribed
  - an assessment of the risk posed by the patient to others
  - an assessment of any risk to the patient from deliberate or accidental self-harm, and
  - an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.

(See Appendix 21 for advice for doctors for medical reviews).

4.7 The **Ward staff** have the following responsibilities:

- To ensure that they have a good understanding of the seclusion and long term segregation policy and are suitably trained and up to date in the use of de-escalation and Prevention and Management of Aggression (PMA) skills.
- To consider approaches to de-escalation of violence in accordance with the PMA Policy and MAPA training, and exhaust all alternative less restrictive options prior to the use of seclusion or segregation.

- To inform patients of their rights whilst in seclusion/ segregation, and to ensure their individual needs are met (including cultural, religious and gender needs etc.). All communications, both verbal and written, must be in an appropriate format to meet the needs of the patient and their carer etc.
- To undertake direct and indirect observation as outlined by the policy and report any difficulties to the nurse in charge (observation to be undertaken as continuous, unless assessed and otherwise agreed by the clinical team).
- To ensure that everything required for a direct review is available in a timely manner, e.g. food & fluids, medications, staff required to enter.
- To complete all required documentation and report each incident of seclusion on an electronic incident report form (eIRF).
- To ensure that care plans are tailored for managing disturbed behaviour and are reviewed following an episode of seclusion.
- To liaise closely with medical colleagues, and inform them of physical health concerns or prolonged restraint.
- To communicate any deviation from the policy to senior managers/ matrons, and report as an eIRF.
- It is the responsibility of **medical and nursing staff** to work to achieve policy standards and to report any deviation from this policy to the operational manager/ Matron, and to complete an Incident Report Form.

4.8 The **Nurse in Charge** will have the following responsibilities:

- All above duties of ward staff.
- Will liaise with the Clinical Duty Manager/Coordinator to ensure that seclusion reviews are coordinated across the units.
- Be responsible for ensuring the completeness of all seclusion documentation carried out, during their shifts, including checking direct observations by nursing staff during the reviews.
- To alert the Responsible Clinician and/or duty doctor that a patient is being nursed in seclusion and requires medical review.
- Ensure all documentation is collated and completed, following termination, to be reviewed by the Ward Sister/Charge Nurse.

4.9 The **Duty Coordinator / Clinical Duty Manager or Nurse in Charge (for areas without a coordinator/duty manager)** will:

- Undertake regular checks across all inpatient settings over the 24 hour period to ensure that staff are fulfilling their roles and responsibilities.
- To support with senior leadership and guidance for staff who are not familiar with the seclusion policy, particularly areas that do not regularly use it.
- .
- •The Duty Co-ordinator/ Manager will have overall responsibility/oversight of the coordination of seclusion / long term segregation directs by the nurse in charge of the area and will participate in reviews as required by the policy. Ensuring that the Area which started seclusion follows policy and the area organises relevant reviews in line with policy.

- Ensure the attendance of the relevant medical professionals during periods of prolonged seclusion out of hours and escalate if there are issues with non-attendance out of hours.

4.10 The **Prevention and Management of Aggression (PMA) Trainers and Safeguarding Team** will:

- Ensure the provision of high quality training in the use of de-escalation and PMA skills. The PMA/ Safeguarding team will participate in MDT reviews for patients who have been secluded/ segregated as required, and will respond to clinical staff's requests for support and advice.

4.11 **Clinical Staff**

- Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.
- In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded.
- Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following;
- Understand information about the decision
- Remember that information
- Use the information to make the decision
- Communicate the decision
- Where this occurs a best interest decision should be taken involving the person's family / carers.

5.0. Training needs

5.1 Seclusion and long term segregation awareness is incorporated into the Trust PMA training. This is mandatory role specific training and compliance is monitored via the Trust Learning & Organisational Development Group

5.2 This policy will be supported by of training and development to ensure that all clinical staff have an appropriate knowledge and understanding of the policy and of best practice.

5.3 Staff involved in any restrictive interventions must be suitably trained and up to date in the use of de-escalation and MAPA physical holding skills (the MAPA five day training course and two day update covers instruction on the use of seclusion). This can be measured via training records and the use of the e-rostering system to ensure that the wards have the right skill mix available in the event of the use of restrictive interventions, more commonly physical restraint and seclusion.

6.0 Use of seclusion

6.1 Seclusion is the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediately necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed for the purposes of seclusion and which serve no other function on the ward. *(MHA Code of Practice, 2015).*

6.2 To be consistent with the MHA Code of Practice (2015), the need for monitoring and regulation starts whenever a patient is locked alone in a room or prevented from leaving a room (see section 8 wards that do not have seclusion facilities).

6.3 Seclusion must only be used in cases where the patient has not responded to alternative interventions (such as de-escalation) and can no longer be safely managed in an open environment. NICE guidelines (2015) require staff to consider rapid tranquillisation or seclusion as an alternative to prolonged physical restraint (i.e. longer than 10 minutes). The patient's behaviours must be such that they present an immediate and significant risk to others (i.e. patients, staff/contractors and visitors).

6.4 Seclusion must be used:

- as a last resort only for management of acute behavioural disturbance;
- for the shortest possible time; and
- in a room specifically designated as a seclusion room.

6.5 Seclusion must not be used as:

- a punishment or threat;
- as part of a treatment programme (although it may feature in a patient's advance statement of wishes);
- because of staff shortages;
- where it will exacerbate the risk of suicide; or
- as a method of controlling self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion must be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety and that any such risk can be properly managed (MHA Code of Practice 2015).

6.6 The following practice **should be** recorded as seclusion:

- A patient is locked in a seclusion room
- A patient is locked in a bedroom
- A patient is placed alone in a room and prevented from leaving either by the door being locked, held shut or staff standing in the doorway preventing the patient from leaving.
- Where a patient asks to be isolated from others and is then prevented from leaving the area in which they are isolated.

- Where a patient is in an area and staff have concluded all physical interventions or verbal de-escalation, however it is felt that the patient is unable to leave the area and is prevented by staff from leaving, even if the staff remain with them.

Any seclusion that does not take place in a designated seclusion room, should be reported as 'seclusion – other' on the eIRF system.

6.7 The following practice **should not be** recorded as seclusion

- If a patient is being restrained by staff, they are not being secluded.
- If a patient is told to go to a particular area but is free to leave that area, they are not being secluded.

6.8 Children and young people under 18

- In the case of children and young people under the age of 18, the use of restrictive interventions may require modification to take account of their developmental status. The legal context within which restrictive interventions are used with children and young people is different from adults; key aspects of this are explored in the following paragraphs. For further information on children and young people more generally, see MHA Code of practice (1983) chapter 19
- Service providers should ensure that staff involved in the care of children and young people who exhibit behavioural disturbance are able to employ a variety of skills and strategies that enable them to provide appropriate help and support. In most cases restrictive interventions will only be used if they form part of the care plan, positive behaviour support plan or equivalent and have therefore been developed with input from the child or young person and their family/carers where possible.
- Staff should always ensure that restrictive interventions are used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.
- When antipsychotic medication is used to sedate a child or young person, special consideration should be given to risks relating to their developing central nervous system, especially when the medication is given to children or adolescents who do not have a diagnosed psychosis.
- The size and physical vulnerability of children and young people should be taken into account when considering physical restraint. Physical restraint should be used with caution when it involves children and young people because in most cases their musculoskeletal systems are immature which elevates the risk of injury.
- Seclusion can be a traumatic experience for any individual but can have particularly adverse implications for the emotional development of a child or young person. This should be taken into consideration in any decision to seclude a child or young person. Careful assessment of the potential effects of seclusion by a trained child and adolescent clinician is required, especially for those children and adolescents with histories of trauma and abuse, where other strategies to de-escalate behaviours may be more appropriate than the use of seclusion.

- In children and young people's services where 'time-out' processes are used, provider policies should differentiate between time-out and seclusion. Time-out is a specific behaviour change strategy which should be delivered as part of a behavioural programme. Time-out might include: preventing a child or young person from being involved in activities which reinforce a behaviour of concern until the behaviour stops; asking them to leave an activity and return when they feel ready to be involved and stop the behaviour; or accompanying the child or young person to another setting and preventing them from engaging in the activity they were participating in for a set period of time. If time-out processes have the features of seclusion, this should be treated as seclusion and comply with the requirements of the Code.
- Restrictive interventions must only be used with great caution on children and young people who are not detained under the Act. As noted in paragraphs 26.73 and 26.106, if there are indications that the use of restrictive interventions (particularly physical restraint or seclusion) might become necessary, consideration should be given to whether formal detention under the Act is appropriate. A person with parental responsibility can consent to the use of restrictive interventions where a child lacks competence or a young person lacks the capacity to consent, but only if the decision falls within the 'scope of parental responsibility' (see MHA Code of Practice (1983) paragraphs 19.38 – 19.43).
- For young people aged 16 or 17 who are not detained under the Act and who lack capacity to consent to the proposed interventions, the use of restrictive interventions in the young person's best interests will not be unlawful if they meet the requirements in section 6 of the MCA and do not amount to a deprivation of liberty (see paragraph 26.49).
- Staff having care of children and young people should be aware that under section 3(5) of the Children Act 1989 they may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'. Whether an intervention is reasonable or not will depend, among other things, upon the urgency and gravity of what is required. This might allow action to be taken to prevent a child from harming him/herself, however it would not allow restrictive interventions that are not proportionate and would not authorise actions that amounted to a deprivation of liberty.

7.0 Seclusion rooms

7.1 Only rooms which have been specifically designated as seclusion rooms may be used for the purpose of seclusion. These must meet the minimum requirements set out the in Healthcare Building Note 03-01; Adult Acute Mental Health Units (2013). Such rooms must not be used for any other purpose other than the de-escalation and management of behaviour.

7.2 These rooms are characterised as:
- Providing privacy from other patients
- Enabling staff to maintain observation at all times
- Safe and secure
- Not containing anything which could cause harm to the patient or others;
- Adequately furnished, heated, lit and ventilated

- Incorporating tamper-proof mechanical and electrical services fittings – the lighting, water and electrical override controls should be external to the suite; and
- Having some means of calling for attention. This will be evident and explained to the patient in an appropriate manner.

7.3 The following factors are additionally specified in the Mental Health Act Code of Practice (2015):

- the room should allow for communication with the patient when the patient is in the room and the door is locked, e.g. via an intercom
- rooms should include limited furnishings which should include a bed, pillow, mattress and blanket or covering
- rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
- rooms should have externally controlled lighting, including a main light and subdued lighting for night time
- rooms should have robust door(s) which open outwards
- rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
- rooms should not have blind spots and alternate viewing panels or CCTV should be available where required
- a clock should always be visible to the patient from within the room; and
- rooms should have access to toilet and washing facilities.

The Trust completes a 6 monthly review of seclusion facilities against these standards.

7.4 Where seclusion rooms do not have en suite toileting facilities, a risk assessment will be undertaken to identify the appropriateness of the patient using disposable bed pans or being escorted to the toilet as required. Patients will be informed that a nurse will be in sight and sound at all times, and they can therefore ask for assistance as necessary.

7.5 Ward Sister / Charge Nurses will ensure that a physical check of seclusion rooms is undertaken after use and weekly to identify required repairs or further cleaning. Ward sister / Charge nurses are responsible for putting a system in place to ensure that seclusion rooms are clean and fit for use whenever they are required in an emergency situation.

7.6 A patient information leaflet will be available across all inpatient ward settings to ensure that service users are aware of the use of restrictive practices including the use of seclusion and long term segregation.

7.7 Care plans and risk assessments must be tailored for managing individual's disturbed behaviour and reviewed as necessary following each episode of seclusion as part of the post-seclusion review under the supervision of the Ward Sister / Charge Nurses. Care plans will be reviewed following recurrent episodes of seclusion to ensure that patient preferences are reflected in the care plan.

7.8 Due to limited facilities some areas use the Seclusion rooms for de-escalation. As part of the approaches to least restrictive practice this is acknowledged and accepted. When using the room in this way the door should remain open at all times and should not impact on the availability of a seclusion room for its original design purpose.

8.0 Wards that do not have seclusion facilities

8.1 Wards that do not have such a facility, or where the ward seclusion room is already in use, will need to access designated seclusion rooms in neighbouring wards as per local agreements considering same sex compliance. This will be done following careful consideration to the privacy, dignity and safety of the patient, of fellow inpatients, visitors and staff. The coordinator or nurse in charge may need to temporarily close off general access to corridors or areas of the ward in order to be able to achieve a safe and dignified ward-to-ward transfer.

8.2 The healthcare record must be stored on the ward on which the patient is secluded or segregated. An entry in the notes must be made to state the date and time of relocation and to which ward. The unit coordinator will make a decision about the responsibility for undertaking observations where a patient is secluded on a neighbouring ward in this case.

8.3 It is the responsibility of the nurse in charge of the parent ward to complete all documentation and to conduct the post-seclusion review.

8.4 Where there is no access to an appropriate seclusion area as described above and staff have concerns about their ability to safely manage a patient within the standards outlined within the Seclusion Policy, this must be immediately escalated to the responsible clinician, clinical director and the relevant senior manager.

8.5 To be consistent with the MHA Code of Practice (2015), the need for monitoring and regulation starts whenever a patient is locked alone in a room or prevented from leaving a room by a fixed physical barrier and separated by staff as defined in section 6.6

9.0 Decision to seclude

9.1 After de-escalation strategies have been exhausted, the decision to seclude can be made in the first instance by a doctor, a suitably qualified approved clinician, or deputy, or the nurse in charge of the ward.. The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion.

9.2 If seclusion was not authorised by a psychiatrist, then the nurse in charge must contact the Responsible Clinician (RC) to inform them of the initiation of seclusion to organise the first internal multidisciplinary review. If the RC is unavailable or this occurs out of hours, then the duty doctor must complete an initial review within the first hour of seclusion. The nurse in charge must also ensure that the Duty Coordinator/Clinical Duty Manager or On-call manager are informed of period of seclusion.

9.3 Where there is a delay in the doctor's attendance, the nurse in charge must document verbatim the doctor's instructions into the patient records, and reasons for the delay, and inform the Duty Coordinator, or equivalent who should escalate to the Registrar or On-Call Consultant.

9.4 The nurse in charge of the ward is responsible for ensuring that the seclusion recording sheet is completed contemporaneously (see Appendix 9). Accuracy of completion will be routinely reviewed as part of the enhanced seclusion review.

9.5 The decision to seclude must be explained to the patient in an appropriate manner at the first available opportunity, outlining the particular behaviour which has necessitated the use of seclusion. This explanation must be given in a manner appropriate to the individual's needs; this may include the provision of an interpreter, hearing assistance or other means of communication aids. The discussion must be detailed in the patient record and include supporting information regarding the patients understanding.

9.6 The first hour of indirect observations should be completed by a Registered Nurse, who is able to ensure that the documentation for seclusion is complete and the Seclusion care plan, this will ensure that a suitable assessment of risk has occurred prior to the first direct review. The nurse will also be able to monitor the patient's physical health if they have been given Rapid Tranquilisation prior to the episode of seclusion.

9.7 Where it has been agreed in a care plan/positive behaviour support plan that family members will be notified of significant behavioural disturbances and the use of restrictive interventions, this should take place as agreed in the plan.

9.8 After seclusion has been initiated, staff must be given a post-incident debrief to identify and address ongoing risks, physical harm and also ensure that other witnesses, patients or visitors are debriefed/supported.

9.9 A seclusion log book will be kept in the clinical area that provides details of the patients NHS number, date and circumstances that lead to the decision and the authority to seclude. This log book must be available at all times for inspection by management teams or CQC on request. The log book can then be cross referenced with the full seclusion documentation which will be in the patients' notes. The log book will be pulled from the incident reports on a monthly basis and will be stored in the Positive & Safe Shared Drive to be accessed by Ward Sisters/Charge Nurses/Matrons and Managers.

10.0 Assessing the Risk

10.1 Every patient being secluded must be searched and checked for hazardous items prior to the commencement of seclusion. Items left with the patient must be taken into account for the likely risk posed. This must be carried out in accordance with the Trust's Searching of Inpatients and their Property Policy.

10.2 The patient's clothing and personal items (including those of religious or cultural significance) must only be removed if there is an identified risk of the patient

harming themselves, in which case this must be clearly documented. Clothing will not routinely be removed. If the decision is made to remove clothing, then the patient must be offered the opportunity to remove their own clothing in the first instance and before staff intervention. This needs to be done with the consent of the patient wherever possible and documented on the seclusion sheet. At least one member of staff of the same gender as the patient must be present.

10.3 The patient will be provided with adequate clothing that will maintain dignity during their time in seclusion. All areas with a seclusion facility will have adequate alternative clothing available (for example seclusion gown), however, best practice is to use the patient's own clothes where safe to do so.

10.4 If clothing has been removed, the necessity for this to continue must form part of the regular review and be documented in the healthcare record.

10.5 Where a patient is in seclusion, unless a medical assessment concludes otherwise, their usual drug therapy (particularly for medical conditions) must be administered. Rapid tranquillisation, if needed, must be undertaken with caution and in accordance with the policy. Consideration must be given to ending seclusion once rapid tranquillisation has taken effect.

10.6 The attending doctor needs to be made aware of any physical conditions and injuries, noted or expressed by the patient and doctors must document their physical assessment and any actions taken or new medications prescribed. A body map (appendix 7) needs to be completed at the commencement of seclusion, and this should show whether there are injuries or not at the point of seclusion.

10.7 If a patient is subject to prolonged restraint or has been subjected to pepper spray or Taser by the police prior to or during the seclusion process, a full medical review will take place at the earliest opportunity.

10.8 If the patient is thought to have been using illicit drugs or alcohol, then a drug or alcohol screening test must be considered prior to seclusion. If the patient is too unwell then regular checks need to be maintained and recorded related to their physical state, to ensure no problematic withdrawal symptoms are present and for patient safety. These would include vomiting, seizures, shaking and tremors. If the substance is known it must be recorded prior to seclusion. If behaviour is related to substance use this must be documented on the seclusion form and in the healthcare record.

10.9 Where seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors, facilitating brief periods of access to secure outside areas or allowing meals to be taken in general areas of the ward. The possibility of facilitating such flexibility should be considered during any review of the ongoing need for seclusion. Particularly with prolonged seclusion, it can be difficult to judge when the need for seclusion has ended. This flexibility can provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without terminating the seclusion episode.

11.0 Rapid tranquillisation

11.1 Rapid tranquillisation at an early stage may remove the need for seclusion, but if seclusion is required, the following advice must be carefully considered and followed:

- If the patient is secluded, the potential complications of rapid tranquillisation must be taken particularly seriously.
- The patient must be closely observed and monitored in accordance with the requirements of the Rapid Tranquillisation Policy
- Once rapid tranquillisation has taken effect, seclusion must be reviewed

11.2 The Rapid Tranquillisation Policy/ Guidelines must be followed, and the relevant forms completed.

12.0 Reviewing seclusion

12.1 Once a patient has commenced a seclusion episode, the need for seclusion must be kept under constant review with the aim of ensuring that seclusion is terminated as soon as possible. The nurse in charge of the ward is responsible for ensuring that individuals are informed and reminded of the need to follow the review timetable, as outlined in section 14-18. The patient must be informed that reviews will take place.

12.2 The review will be by direct observation, unless, in extreme circumstances, where there is evidence that this would pose an unacceptable level of risk. Levels of observation and risk must be reviewed and a record made of agreed decisions.

12.3 The review must focus on:

- The condition and behaviour of the patient and whether the continued use of seclusion is appropriate;
- What is required to terminate seclusion, what are we expecting from the patient? Is there something we could do differently to stop seclusion;
- The initial incident that led to the period of seclusion and plans should something similar happen again;
- This should include developing the patients care plan in line with the positive behaviour support principles to try and avoid future incidents;
- Factors which would lead to the need for review outside of the normal time-scales; and
- The seclusion environment and the appropriate facilities that need to be made available to the patient whilst in seclusion.

12.4 The initial review occurs when the doctor (a suitably qualified approved clinician, or deputy), the nurse in charge of the ward and duty coordinator (wherever applicable) arrive on the ward, having been informed that the patient has been secluded. The reviewing team should be clear of the roles and duties on entering seclusion, who is carrying out physical observations, who will be communicating with the patient, if medication are being given, cleaning and providing fresh drinks/food.

12.5 The doctor must ensure the seclusion is included in handover at the end of the shift to another doctor, to advise when the next review is due to take place.

12.6 An on-call doctor is available to carry out a medical review during the night. The nurse in charge of the ward is responsible for calling the doctor in advance of the required direct observation reviews.

12.7 Any difficulties in meeting the timetables for review and assessment must be clearly documented by the nurse in charge of the ward and resolved as soon as possible. These should be escalated with support by the coordinator/duty manager to find a doctor who is able to attend (e.g. on-call Registrar)

12.8 If at any time there are concerns regarding the patient's wellbeing, the doctor will be contacted immediately to reassess the appropriateness of the continuation of seclusion. This review will include a documented assessment of both the mental and physical state of the patient.

12.9 The nurse in charge of the ward is responsible for ensuring the completion of the seclusion observation recording (Appendix 9)

12.10 Seclusion Reviews must be documented using the Direct Observations Sheet (Appendix 12) to capture the names, designations and signatures of those in attendance. A entry should be completed within the Electronic Patient Record using the proforma identified (Appendix 20)

13.0 Review Timetable

13.1 Reviews must be conducted in line with the Seclusion Review Flowchart (Appendix 11)

14.0 Nursing Review

14.1 Nursing reviews should be completed every 2-hours from the commencement of seclusion by **two registered nurses**, one of whom was not involved in the decision to seclude. Where this is not possible it must be agreed with Clinical Duty Manager/ Manager and Matron/ Lead Nurse and documented on the 'Review of Seclusion'.

14.2 One of the two registered Nurses involved in the 2-hourly nursing review should be a nurse from the part of the register in which best represents the patient's needs, i.e. mental health or learning disability.

14.3 Nursing reviews will:

- Ensure the patient is safe.
- Ensure there are no physical health concerns which require review / medical review.
- Include physical health monitoring (respirations, oxygen saturations, pulse and blood pressure) if the patient is compliant and where safe to do so. If the patient is not compliant or it is unsafe to enter the seclusion the reason for not completing

oxygen saturations, pulse and blood pressure should be clearly documented on the Record of Seclusion / Review of Seclusion and within the patient electronic record.

- As a minimum, respirations should always be completed.

14.4 The outcome of the Nursing Review should be documented on the Review of Seclusion documentation, including the reason the seclusion should continue.

14.5 The timing for review should be **sequential** from the start of seclusion not from the time each subsequent review takes place.

15.0 Medical Review

15.1 The first medical review will be completed by the doctor (medical) within 60 minutes of the initiation of seclusion unless the seclusion was initiated by the Psychiatrist

15.2 If seclusion is to continue the clinical team should agree a seclusion care plan. (Appendix 8) although not exhaustive, outlines the main issues to consider when developing a seclusion care plan.

15.3 Medical reviews should continue every 4 hours from the **point of seclusion** by a doctor (medical) alongside the registered nurse. Four-hourly medical reviews should be **sequential** from the start of seclusion **until the first Internal MDT Review**. Following which, further medical reviews should be completed at least twice in every 24-hour period (MHA, Code of Practice 26.132).

15.4 Medical reviews should be carried out by a medical doctor, for example the patient's responsible clinician if they are medically qualified, a medically trained approved clinician or a duty doctor. Any duty doctor will have access to an on-call approved clinician for advice if required via LPT Switchboard.

15.5 Medical reviews provide the opportunity to evaluate and amend seclusion care plans, as appropriate (See MHA, Code of Practice, paragraph 26.147 re care plans). They should be carried out in person and should include, where appropriate and an entry should be documented in the electronic patient record.:

- a review of the patient's physical and psychiatric health
- an assessment of adverse effects of medication
- a review of the observations required
- a reassessment of medication prescribed
- an assessment of the risk posed by the patient to others
- an assessment of any risk to the patient from deliberate or accidental self-harm, **and**
- an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner

15.6 The outcome of the Medical Review should be documented on the Review of Seclusion documentation, including the reason the seclusion should continue and an entry should be put on the Electronic Patient Record.

16.0 Internal Multidisciplinary Team Review

16.1 **Initial Internal MDT Review** The MHA Code of Practice (26.137) indicates that "The first MDT meeting should be held as soon as is practicable." Ideally, the first four-hourly medical review will involve members of the MDT and can also be recorded as the initial internal review. Where this is not possible or occurs out of hours, then the medical reviews will need to continue 4 hourly, until the first internal MDT review with RC or covering Consultant.

16.2 This should be within 24-hours of the seclusion commencing If it is concluded that seclusion needs to continue, the review should establish the individual care needs of the patient while they are in seclusion and the steps that should be taken to bring the need for seclusion to an end as quickly as possible.

16.2 **Subsequent Internal MDT review** The MHA Code of Practice (26.139) indicates that internal MDT reviews should take place once in every 24-hour period of continuous seclusion. LPT's stance is that this may take place with one of the required medical reviews or in addition to the medical review

16.3 Membership of the Internal MDT review to include the Responsible Clinician, nursing staff and staff from other disciplines who would normally be involved in the patient's reviews. Membership out of hours (overnight, weekends and public holidays) will be the covering Consultant alongside Clinical Duty Manager/Coordinator and Nurse in Charge.

16.4 The outcome of the Internal MDT Review should be documented on the Review of Seclusion documentation, including the reason the seclusion should continue.

16.5 The seclusion care plan should also be evaluated and amended as appropriate (MHA, Code of Practice 26.140).

16.6 **Independent MDT review**

If the patient is secluded for more than:

- 8 hours consecutively **or**
- 12 hours intermittently over a period of 48 hours

then an additional Independent MDT review should be completed promptly but by 12 hours after the seclusion commenced. The arrangement of the independent MDT review is to be agreed by the RC and the ward sister/charge nurse or delegates.

16.7 The Independent MDT review should be completed by a medical doctor or suitably qualified non-medical AC / RC (or identified deputy) and nurses and other professionals who were not directly involved in the decision to seclude the patient or in the prior incident. IMHAs (in cases where the patient has one) will also be invited to the review. Good practice indicates that the Independent MDT consult with staff involved in the original decision to seclude the patient (MHA, Code of Practice 26.142).

16.8 If the Independent MDT review concludes that the “seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion plan” (MHA, Code of Practice 26.143). The Review of Seclusion documentation should be completed.

16.9 The outcome of the Independent MDT review, timescales for further Independent MDT review and rationale for timescales, must be recorded on the direct observations review and update the patient’s Electronic Patient Record.

17.0 ALL REVIEWS

17.1 If the need for seclusion is disputed by any member of the multidisciplinary team, following initial discussion with Ward Sister/Charge Nurse, the matter will be referred to a Matron or Lead Nurse and the Medical Lead and further dispute should be referred to the Head of Nursing and Clinical Director.

17.2 Where appropriate and necessary, members of the PMA and Safeguarding Team must be involved in reviews and discussions about future management of patients in prolonged seclusion.

17.3 If for any reason direct or indirect observations cannot take place in line with the policy then the nurse in charge of the ward must inform the coordinator/ Clinical Duty Manager who will assess the necessary action and inform senior managers and clinicians as required.

17.4 The patient involved in the seclusion must be offered the opportunity to input their views and perspectives into the review and these must be documented and considered in conjunction with all multi-disciplinary perspectives.

17.5 Further guidance on reviews can be found in section 26 of the MHA Code of Practice, 2015.

18.0 Sleeping Patients

18.1 A patient cannot be deemed to present a risk to others when asleep. No patient should remain in seclusion longer than necessary but conversely no patient should be woken, especially after a period of disturbance where risk assessment indicates this will result in further seriously disturbed behaviour. The nursing care plan needs to be amended to reflect the patient’s current care and management.

18.2 If a decision is made not to go in and directly review a sleeping patient but the risk to others is still felt to be high then seclusion may continue. This decision must be made in conjunction with the Nurse in Charge / CDM / Co-ordinator, Senior Nurse independent of the ward. All involved must be able to see evidence of breathing at all times.

18.3 The decision must be documented in the patient electronic file and on the seclusion record.

18.4 If the patient appears asleep, consideration must be given to discontinuing seclusion. If this is deemed appropriate by the multi-disciplinary team and/or the nurse in charge, the door must be opened, and at least one member of staff must remain outside the room observing the patient. The rationale for the decision to either continue or end seclusion, and the professionals involved in the discussion, must be documented. When seclusion is ended and the patient is still asleep, the patient should be allowed to stay in the seclusion room until they wake or the next morning whichever comes first. If a patient is left to sleep in the seclusion room, continuous observations should continue until they awaken to avoid disorientation and to assess risk

19.0 Observation

19.1 A suitably skilled professional must be readily available within sight and sound of the seclusion room at all times during the period of a patient's seclusion. The professional should have the means to summon urgent assistance from other staff at any point. Consideration should be given to whether a male or female staff member should carry out ongoing observations; this may be informed by consideration of a patient's trauma history. The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end.

This will necessitate continuous observation, which according to LPT's Safe and Therapeutic Observation of Inpatients Policy is defined as follows:

> *The patient must be in sight of the nurse at all times but not necessarily at arm's length. The nurse needs to be close enough to the patient to enable effective intervention at any time if required. The patient must be in sight of the nurse at all times by day and by night and any tools or instruments that could be used to harm self or others must be removed.*

19.2 It may not be appropriate to constantly watch the patient, for example for reasons of sexual disinhibition, extreme paranoia or active attempts to break out of the seclusion room. CCTV, where available, may enable staff to have a better view of the patient without being unnecessarily obtrusive. However, observing staff must be mindful of any blind spots when carrying out direct observation in both viewing panels and CCTV and for a full view of the patient it is likely both will be utilised. Staff should also be mindful of the need to be fully focussed on the task of observation and readily available within sight and sound of the seclusion room at all times.

19.3 If the patient cannot be seen or heard due to barricading or obscuring the view, the observing nurse should raise help immediately and a clinical decision made as to whether to carry out a Direct review at that point made.

19.4 Seclusion observations should be documented on the observations sheet (Appendix 10) at a minimum of every 15minutes however there maybe need to record behaviour or conversations more frequently. This entry will cover the patient's wellbeing over the previous 15 minutes. The observation's should be in line with the Therapeutic observation policy covering the patient's appearance, what

they are doing and saying, their mood, their level of awareness and any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis. The Trust requires that seclusion be recorded by the following means:

- Completion of the Seclusion Recording Forms
- Detailed entry in the patient's clinical record (to include rationale for use of seclusion, description of behaviour, risk assessment, de-escalation attempts and chronology of events, including seclusion start time and summary of observations whilst in seclusion)
- Ensuring the observation form during seclusion are scanned onto the patient record as soon as possible
- Development of a seclusion care plan
- Completion of electronic Incident Report Form (eIRF)

Any failure to complete the above will be considered under the performance and conduct management procedures.

19.5 The first hour of observations should be completed by a Registered Nurse and then at least 2 hours per shift must be completed by Qualified Nursing Staff (either a Registered Nurse or Registered Nursing Associate). This will allow for a more robust assessment of the patient's presentation in seclusion to support the direct reviews.

19.7 The member of staff must remain within sight and sound of the seclusion room with their sole duty being to support the patient at all times during the period of seclusion.

19.8 The type of observation is defined as:

- ***Direct observation*** *- Entry into the seclusion room review and assess the physical and mental state of the patient to determine whether the seclusion should continue. No staff must ever enter the seclusion room alone, or be left alone, with a patient in seclusion. There must be a minimum of three appropriately trained staff available for direct observations.*

- ***Indirect observation*** *- Observation through the locked seclusion room door to ascertain the safety of the patient and observe behaviour. As a therapeutic intervention staff should be encouraged to engage the patient through the locked door when appropriate. During indirect observation the staff member must be able to see that the patient is breathing, this is vital for patients who have been restrained prior to seclusion, received PRN or Rapid Tranquilisation medication, have known medial conditions that may be affected by the above and patients who are in the prone position by choice.*

19.9 For children and young people under 18, a member of staff will remain in the room with the patient at all times. The patient will be on continuous observation and the number of staff required to care for the patient will be decided on an individual basis, bearing in mind the principles of least restrictive practice and Trust guidance

on safe age appropriate MAPA holding skills. The member of staff must be able to communicate with other members of staff and an emergency protocol must be in place.

20.0 Care planning to protect patients' rights and meet individual needs

20.1 Staff must ensure that patients who are assessed as being liable to present with behavioural disturbance have a care plan, modelling the principles of a positive behaviour support plan.

20.2 For a seclusion specific care plan guidance can be found in Appendix 9. It must be clear that seclusion is not a therapeutic intervention, and is only to be used in the management of extreme risk. However the Trust accepts that some patients request via advanced directives access to seclusion.

20.3 Patients in seclusion have the following rights and have the right to have them explained both in writing and verbally. The nurse in charge of implementing seclusion must ensure the rights are given to the patient at the earliest appropriate opportunity and in the most appropriate format:

- To be treated with dignity at all times.
- Respect the diverse need, values and circumstances of each patient including religion and belief
- To be given the reason for being placed in seclusion
- To be told under what conditions seclusion will cease
- To be aware of the time and day
- To be told how to summon the attention of staff whilst in seclusion
- To receive adequate food and fluids at regular intervals
- To be given appropriate access to toilet and washing facilities (where continued observation is required, only staff of the same gender should be present)
- To be clothed at all times
- To be visited by, and given the opportunity to speak to, a senior staff member at regular intervals during the seclusion period.
- To be allowed to send messages to relatives or carers through the ward nursing team. Where seclusion is required for longer period's access to family/ friends and legal representatives should be considered In an MDT risk assessment.

20.4 A record must be made on the Recording Sheet for Commencement of Seclusion (Appendix 6) that the patient has been informed of these rights. The relevant leaflet may be offered as appropriate.

20.5 The secluded patient's religious beliefs and practices should to be taken into consideration. Dates of particular religious festivals may have an impact on the secluded patient, and such will need to be considered and addressed on an individual basis.

21.0 Nutrition and hydration monitoring

21.1 Regular fluids and food will be provided and they will be documented on the seclusion observation recording sheet, (Appendix 10). It is important that food

provided and the manner in which it is provided is determined by the risk presented and taken into account in continuing to respect the patient's dignity and cultural needs. Fluids must be offered every 2 hours on direct observations, assuming the patient is awake.

21.2 The provision of culturally appropriate dietary intake must always be maintained.

22.0 Personal care monitoring

22.1 The patient will also be provided with toilet and washing facilities and every effort must be made to respect the individual's privacy and dignity.

22.2 Every consideration must be given to the spiritual and cultural needs of a patient in seclusion, and appropriate means to enable the person to undertake their method of worship.

22.3 Interpretation and translation services must be provided to ensure the dignity and respect of all patients is maintained. This should include alternative language, British Sign Language, larger print or easy read format to meet accessibility needs. Other communication aids used by the patient should be made available to them where appropriate.

22.4 All steps will be taken to avoid the seclusion of patients who are intoxicated from the use of alcohol or un-prescribed drugs. In the event of this being unavoidable, the attending doctor will undertake a full medical review on commencement of the period of seclusion.

22.5 Consideration must be given for the patient to be given access to at least basic diversions such as papers or magazines especially in prolonged seclusion. Consideration must be given to informing relatives and carers that the patient is in seclusion, if appropriate. Patients will not usually receive visitors whilst in seclusion to ensure all parties safety; any request regarding visitors will be discussed in the MDT meeting and if felt appropriate, risk assessed. .

23.0 Mental Health Act Status

23.1 In the event of an informal patient being placed in seclusion, their status must be reviewed by the attending doctor in order to immediately assess the need for a formal detention.

23.2 Where the outcome of the assessment is that the patient is not detainable under the Mental Health Act, then seclusion must be terminated.

23.3 Where a patient is on a DOL prior to the seclusion taking place, the ward should advise the Supervisory Body that a Part 8 review is required, further guidance on this is found in the Trusts DoL's Policy. Staff should seek advice from the Local Authority if there is any doubt.

23.4 If a non-detainable patient is assessed as having capacity but the level of violence remains a risk to others, consideration will be given to continuing the period of

seclusion to enable the involvement of the police at the earliest opportunity in order to remove the patient from the premises. Following multi-disciplinary discussion, the patient will be discharged in consultation with the police.

23.5 Change in the patient's Mental Health Act status must be recorded on the seclusion record.

24.0 Termination of seclusion

24.1 A period of supportive testing may be included prior to seclusion ending as discussed and agreed by the MDT i.e. what is required about the patient's presentation for seclusion to end, during the review of seclusion.

24.2 Supportive testing may take place in a seclusion room, or where available, a de-escalation room within the seclusion area. Time spent in compliance testing within seclusion room or de-escalation area will be included in the total seclusion episode timeframe and recorded as such.

24.3 Seclusion ends when a patient is allowed free and unrestricted access to the normal ward environment or transfers or returns to conditions of long term segregation

24.4 Termination of seclusion must occur as soon as possible and should immediately end when a MDT review, a medical review or the independent MDT review determines it is no longer warranted. Staff must be informed by the patients care plan which may include any preferences for managing seclusion or repeated seclusion.

24.5 Where practical, the decision to terminate must be agreed between the nurse in charge of the ward, by a doctor, a suitably qualified approved clinician and the duty coordinator. However, it is appropriate for the nurse in charge of the ward to make the decision to end seclusion, and the nurse must ensure that the responsible clinician is notified at the earliest convenience.

24.6 In the event of a disagreement, an urgent multi-disciplinary team review must be arranged. See section 17.1

24.7 There may be occasions where traditional seclusion and other restrictive practices are used in combination, for example a patient has left the seclusion room but immediate access to the level of freedom afforded to other patients on the ward is assessed to be unsafe; for example, the patient may remain in the extra care area. At such times, patients should continue to be subject to monitoring, review and recording consistent with seclusion.

24.8 As part of a Positive Behaviour Support programme, a gradual approach to ending seclusion may be appropriate for children and young people under 18, particularly if the seclusion was due to the need of a low stimulus environment to maintain the patient's safety, or that of others.

24.9 The nurse in charge is responsible for the completion of all relevant documentation regarding termination and the decision for ongoing observation, and this will then be quality checked by the Ward Sister/Charge Nurse or a nominated deputy.

25.0 Post seclusion review

25.1 The post incident/seclusion review is to review the needs of our patients and the reasons behind incidents. The form is to be completed by the nurse in charge to review the incidents prior to seclusion and the seclusion experience and termination. This is to develop better care plans to avoid further incidents and highlight any trauma issues that may have been exacerbated by the seclusion incident. The information should be used with the patient to develop the care plan and risk assessment.

25.2 The process and post seclusion review is best practice and as such will be reviewed with the seclusion packs and signed off by the Ward Sister / Charge Nurse.

26.0 Record Keeping

26.1 It is a legal requirement that accurate records are maintained for each episode of seclusion.

26.2 The Trust requires that seclusion be recorded by the following means:

- Completion of the Seclusion Recording Forms (Appendix 6-15)
- Detailed entry in the patient's clinical record (to include rationale for use of seclusion, description of behaviour, risk assessment, de-escalation attempts and chronology of events, including seclusion start time and summary of observations and reviews whilst in seclusion)
- Ensuring the observation form during seclusion are scanned onto the patient record as soon as possible
- Development of a seclusion care plan
- Completion of electronic Incident Report Form (eIRF)

All fields of the seclusion recording form must be fully completed.

The record keeping responsibilities of specific staff members are as follows:

Nurse in Charge	• It is the responsibility of the NIC during each shift, to ensure the records entered in the seclusion documentation are correct and complete. • NIC should review the observation sheets during the direct reviews to ensure that that are completed.
Nursing staff	• details of who undertook scheduled nursing reviews, their assessment, and a record of the patient's condition and recommendations • completion of seclusion recording sheet – nurse signature every 15 minutes • completion of post-seclusion review

	• completion of electronic Incident Report Form (eIRF)
Medical staff	• details of who undertook scheduled medical reviews, their assessment and a record of the patien • t's condition and recommendations • details of who undertook the independent MDT review, their assessment and a record of the patient's condition and recommendations • details of who undertook the scheduled MDT reviews, their assessment and a record of the patient's condition and recommendations • completion of seclusion recording sheet including signatures in line with review flowchart.
Ward Sister/ Charge Nurse	• completion of Ward Sister/Charge Nurse's quality check
Matron or Team Manager	• Review and sign off of Ward Sister/Charge Nurse's quality check

**** Seclusion documentation will be scanned onto the patients electronic record before the Matron/Team Manager have completed their quality check to ensure that is it available in a timely manner.**

27.0 Long Term Segregation

27.1 Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a patient is not allowed to mix freely with other patients on the ward/unit on a long term basis. In such cases, it should have been determined that the risk to others is not subject to amelioration by a short period of seclusion combined with any other form of treatment; the clinical judgement is that if the patient were allowed to mix freely in the general ward environment, other patients or staff would almost continuously be open to potentially serious injury or harm. *(MHA Code of Practice, 2015).*

27.2 Nursing or caring for a person in enforced isolation, excluding isolation to prevent the spread of infection, regardless of: (1) whether the procedures and requirements of the MHA code of practice 2015 for long term segregation are met, and/or (2) the user of services has periods of interaction with staff and or peers

27.3 This long term segregation procedure applies LPT Trust areas that can meet the environmental requirements of long term segregation.

27.4 Services, both of which at times may provide treatment to patients considered as posing a sustained risk of harm to others as defined in Chapter 26 of the Code of Practice (see box 1).

27.5 It is anticipated that only a very small group of patients within these services will require longer-term segregation. Other services within the Trust will not be expected to provide treatment for such patients.

27.6 Long term segregation refers to a situation in which it is foreseeable that it will be necessary to keep the patient separated from other patients, although not from staff, for an extended period. The multi-disciplinary team and a representative from the responsible commissioning body must determine that a patient should not be allowed to mix freely with other patients on the ward on a long-term basis. The views of the patient's family and carers should be sought and taken into account, and an IMHA should be included in cases where a patient has one.

27.7 The criteria for consideration of the use for long term segregation includes:

- sustained risk to others is a constant feature of the patient's mental state; and
- constant risk to others would be presented if the patient were allowed to mix freely on the ward; and
- short periods of de-escalation, extra care or seclusion would not reduce the risk of harm to others.

27.8 Notes on segregation. The following examples should be recorded as segregation

- *John is in medium secure care. Over the last 4 weeks John has assaulted other patients and several members of staff who attempted to intervene. He has previously been restrained and secluded for short periods of time. Each time John comes out of seclusion he makes threats and assaults other patients. The MDT call a meeting to discuss what to do about John and invite the specialised commissioning case manager and his advocate to attend. His families' views are sought for the meeting. They decide that his behaviour presents a prolonged and continuing risk to the other patients and agree that John should be cared for away from other patients until the therapeutic interventions of staff have reduced his level of risk.. They move John to the extra care area where he has an ensuite room, a small lounge area and, under the supervision of staff, access to a secure outside area.*

- *John is moved to a different extra care area that does not have a separate lounge or access to outdoor space. He is still segregated.*

- *Dorothy has dementia. She has periods of significant confusion and distress which lead to her assaulting other patients and staff. She finds the presence of others in the ward a trigger and the staff make a plan with her family that during these periods she be separated from her peers. She is placed in part of the ward where she can de-escalate with staff but is prevented from integrating with her peer group until her level of distress and confusion reduces. This may range from 2 hours to 5 hours per day. It may not be every day or at the same time.*

- *Chardonnay is autistic and finds busy or noisy periods of time on the ward acutely distressing. This results in her vocalising her distress and engaging in severe self-harming behaviour. It is agreed through her MDT and commissioner that she should be able to access a chill out area at these times, guided into this area by staff. It is known she will de-escalate without further need for restriction if she is able to calm*

in this area. She cannot access the rest of the ward at this time but is able to pace, shout etc. in this area until she calms. Staff remain with her. She accesses this ward area several times a day for short periods.

27.9 The following practice should not be recorded as segregation

- *John assaults a member of staff, is restrained and moved to the seclusion room. (This should be recorded as seclusion).*

- *Colin is escorted to another ward for art therapy and to use the gym. He is the only patient who accesses these services. Colin returns to the ward whenever he is not using the services.*

28.0 Decision to Start Long Term Segregation

28.1 The decision to start a patient in Long Term Segregation, should be planned by the MDT and have involvement of the MDT and include family/carer representation (or IMHA in their absence), as well as the commissioner for the patient. The attendees of this meeting, should be clearly documented.

28.2 The patient will likely to have required frequent episodes of seclusion and the team will be discussing how to reduce these risks long term.

28.3 An MDT Meeting will be held to plan the commencement of Long Term Segregation to get the views of everybody involved in the patient's care. A care plan should be drawn up outlining how to support the patient within the Long Term Segregation and how the criteria has be met, but also, the steps that will occur to end the episode of Long Term Segregation.

28.4 After the Long Term Segregation is agreed, an eIRF should be completed to highlight to Patient Safety Team, Safeguarding Team and Managers that a Long Term Segregation has started.

29.0 Provisions and safeguards

29.1 Whilst recognising the differences in definitions between seclusion and long term segregation within the Code, the Trust considers that this group of long term segregated patients must continue to be subject to the provisions and safeguards offered by the seclusion policy.

29.2 Long term segregation should provide patients with the following:

- accommodation in the least restrictive and most homely environment possible, and with access to a number of areas including bathroom facilities, bedroom, lounge and secure outdoor area
- Access to contact with staff, including enhanced observations, therapeutic interventions and a range of therapeutic activities

- Periodic access to other areas of the unit or spaces away from the unit in accordance with multi-disciplinary risk assessment

29.3 Patients should not be isolated from contact with staff, and they must be supported through constant observation as per the requirements of the seclusion policy. Staff supporting patients who are long-term segregated should make written records on their condition hourly using therapeutic observation sheets.

29.4 The Trust safeguarding team must be made aware of any patient being supported in long-term segregation.

30.0 Review of the need for long-term segregation

30.1 The Trust is committed to following the Code of Practice with respect to the reviews for patients in long-term segregation. As such, review schedules outlined below follow the requirements outlined in Chapter 26 of the Code.

30.2 A care plan must be put in place, which outlines the reasons why long term segregation is required, the observation level, the patient's needs and how these will be met. The care plan must be reviewed daily. Care plans should aim to end long-term segregation, and the patient's care plan should outline how they are to be made aware of what is required of them so that the period of long term segregation can be brought to an end.

30.3 The patient's situation should be formally reviewed by an approved clinician, who may or not be a doctor, at least once in any 24-hour period. This review can be physically conducted by a junior doctor, who discussed the review with an approved clinician. The patient should then have a weekly review by the full MDT. The composition of the MDT should include the patient's responsible clinician, a ward nurse and an IMHA where appropriate. (Appendix 18).

30.4 The purpose of a review is to determine whether the ongoing risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their general health and welfare. The decision to end long term segregation should be taken by the MDT (including consultation with the patient's IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient's presentation during close monitoring of the patient in the company of others.

30.5 Where long term segregation continues for a month or longer, regular monthly reviews of the patient's circumstances and care should be undertaken by the matron, and commissioners must be informed. This requirement applies for either a continual or a regular need to segregate a patient over a period of a month or longer.

30.6 Where long term segregation continues for three months or longer, regular three monthly reviews of the patient's circumstances and care should be undertaken by an external hospital. This should include discussion with the patient's IMHA (where appropriate) and commissioner. The Trust's Learning Disabilities service have

buddied with Nottinghamshire Healthcare NHS Trust to conduct each other's 3 month reviews. The Forensic services have an agreement within the IMPACT Provider Collaborative for external reviews (see Appendix 19)

30.7 The outcome of all reviews and the reasons for continued long term segregation should be recorded using the review of Long Term Segregation Form (Appendix 18) and an entry documented in the patient's electronic record. The responsible commissioning authority should be informed of the outcome of any reviews of continued long term segregation.

30.8 Where successive MDT reviews determine that long term segregation continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner.

30.9 Where appropriate, members of the PMA Team and Safeguarding Team must be involved in reviews and discussions about the future management of patients in long term segregation.

30.10 The patient involved in the long term segregation must be offered the opportunity to input their views and perspectives into the review and these must be documented and considered in conjunction with all multi-disciplinary perspectives. If the patient lacks capacity to do this, then a capacity assessment should be completed and decisions made in their best interests, with support from carer/IMHA.

30.11 At times of acute behavioural disturbance, there may be a need to transfer the patient to a physical area that is more secure and restrictive, and which has been designed for the purpose of seclusion. This change in the care of the individual must be fully documented.

31.0 Procedure for Patients who are being cared for under Long Term Segregation Restrictions who require may require Seclusion

31.1 There may be times when patients who have an authorised on-going Long Term Segregation Plan, become acutely disturbed and require periods of seclusion. The patient, who is under Long Term Segregation restrictions, will have be in a suite of rooms as described in in Section 28.2, with staff observing them on constant therapeutic observations.

31.2 It is recognised in the Mental Health Act Code of Practice, that patients should not be isolated from staff during long term segregation (Ch. 26.152). However, as a method of de-escalation to reduce the need to take a patient to a Trust approved seclusion room, it may be appropriate for staff to remove themselves from the Long Term Segregation area to allow the patient time to calm in a safe environment. Due to the nature of a patient's diagnosis staff may need to withdraw from the Long Term Segregation area, to provide a low-stimulus, calm and safe environment

31.3 This should be clearly outlined as a planned intervention within the patient's care plan as the cogent reasons to deviate from the code as an intervention that have been agreed in advance by the MDT and will not be recorded as seclusion in a non-seclusion area due to it being a planned intervention as they still have access to all of the areas as outlined within their Long Term Segregation Plan.

31.4 If this has not been agreed as a planned intervention by the MDT and is required to manage an episode of acute disturbed behaviour, then it should be managed using the seclusion policy.

31.5 When staff withdraw, a review must take place within 1 hour by two nurses, one of whom must be the nurse in charge, to review the decision to withdraw. If there are concerns about the patient's physical health, then a medical review should occur as soon as possible.

31.6 An electronic incident reporting form (eIRF) should be completed, so that the use of this practice can be monitored within the weekly Long Term Segregation Review.

31.7 There will be a second nursing review at 2 hours, with two qualified nurses to ensure continued safeguards and that food, fluids and medication are offered.

31.8 If the episode of withdrawal of staff continues for 4 hours, then the Responsible Clinician (or covering RC) should be contacted by the Nurse in Charge for review and planning.

31.9 Staff should continue with completion of therapeutic observations and make a note of when they removed themselves from the Long Term Segregation area and when they returned. They will maintain line of sight observations during this period.

31.10 These episodes of staff removing themselves should be evaluated within the patient care plan and be highlighted to the RC during the daily review of Long Term Segregation.

31.11 If a patient who is being in nursed in Long Term Segregation becomes acutely disturbed and requires seclusion for the safety of others, within a Trust approved seclusion room, this should be recorded as seclusion, and seclusion documentation should be used, and incident reported as per the seclusion part of this policy. It will be necessary for direct reviews to be completed, with staff attendance within the seclusion room.

31.12 If a patient is regularly using episodes of seclusion, whilst under the restrictions of Long Term Segregation, consideration within weekly MDT reviews should be considered as to whether the Long Term Segregation restrictions are reducing the sustained risk to others.

32.0 Monitoring the use of long term segregation

32.1 All episodes of the use of long term segregation must be reported using the Trust's electronic incident reporting system.

32.2 The use of long term segregation will also be monitored using a specific audit tool for Long Term Segregation.

33.3 Monitoring Compliance and Effectiveness

33.4 The Trust will ensure that robust governance arrangements are in place and that all reasonable steps are taken to prevent the misuse and misapplication of seclusion, which by it nature is a restrictive intervention. Seclusion activity is regularly monitored and audited by the Trust Positive and Safe Group. Reports will be provided to local management teams, the Trust Board and the Patient Safety Improvement Group.

33.5 The ward sister / charge nurse is responsible for ensuring that the seclusion records are maintained and the information is produced as requested by managers.

33.6 If, for any reason, there is any deviation from this policy, it is the responsibility of the nurse in charge of the ward or unit coordinator to ensure this is immediately communicated to the service manager or senior manager on call if it occurs out of hours. Additionally, an Incident Report Form (eIRF) must always be completed. This must detail what the deviation from the policy was, the reasons for this, and measures taken to prevent reoccurrence.

33.7 All seclusions, without exception, will be reported using the Trust Incident Reporting Policy. Incident data which includes reports of seclusion will be analysed to monitor seclusion activity and provide a ward profile for Ward Sister / Charge Nurses.. This will include the metrics associated with seclusion i.e. start/finish time of each episode, gender etc. for each ward.

33.8 Local management teams are responsible for monitoring the use of seclusion and completing reports as requested. Local management teams are responsible for ensuring that staff involved in seclusions are in date with their PMA and de-escalation skills.

33.9 The Patient Safety Improvement Group is responsible for commissioning Trust-wide seclusion audits. This will take place on an annual basis. Additionally, Ward Sister / Charge Nurses will audit practice in their area on an ongoing basis via post-seclusion reviews and quality checks to ensure policy compliance within their sphere of responsibility. Ward level monthly audit data and documentation will be made available by Ward Sister / Charge Nurses when requested. Any discrepancies or issues for practice identified during audit will be addressed by the ward matron and reported immediately to the general manager.

33.10 It remains the responsibility of the Positive and Safe Group to review, the Seclusion and Long Term Segregation Policy, the Trust Patient Safety Improvement Group to agree the Policy.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
33	Seclusion activity is regularly monitored and audited by the Trust Positive and Safe Group, which meets monthly.	Notes of the Trust Positive and Safe Group	Regular meetings to look at eIRFs, seclusion data and feedback from ward sisters/ charge nurses, Matron quality checks and service user reflection.	Trust Positive and Safe Group reports to the Patient Safety Improvement Group	Ongoing
32	Ward Sister / Charge Nurses are responsible for ensuring that the seclusion records are maintained	Completed matrons' quality checks and service user reflection.	Completed matrons' quality checks signed off by service managers	Ward Sister / Charge Nurses and service managers	Ongoing, and covered in annual audit
33	The Patient Safety Improvement Group is responsible for commissioning Trust-wide seclusion audits on an annual basis	Completed audits, reports and action plans	Patient Safety Group work plan	Patient Safety Improvement Group	Annual

34.0 Standards/Performance Indicators

34.1 This policy document links to Care Quality Commission (CQC) Outcomes as follows:

Specific to; Outcome 4: Care and welfare of people who use services
Outcome 7: Safeguarding, Links to MCA/DoLS.

In support of;
Outcome 16: Assessing and monitoring the quality of service provision
Outcome 21: Records
Outcome 1: Respecting and involving people who use services
CQC domains : 'Safe', 'Caring', and 'Effective'.

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
Monitoring effectiveness will include review of seclusion meetings with nurse manager received at PSEG monthly until the policy is embedded.	Consistent completion of the post-seclusion review and Ward Sister / Charge Nurses quality check.
This will include quantifiable metrics informed by the Local Security Management Specialist on use, times etc. and qualitative feedback from patients and staff to identify key learning and areas requiring action.	Identification of key learning and areas requiring action.

35.0 References and Bibliography

35.1 The policy was drafted with reference to the following:

- LPT Incident Reporting Policy, 2016
- Mental Health Act Code of Practice, 2015
- NAPICU position on the monitoring, regulation and recording of the extra care area, seclusion and long term segregation use in the context of the Mental Health Act 1983: Code of Practice (2015), National Association of Psychiatric Intensive Care and Low Secure Units, 2016
- Positive and Proactive Care: reducing the need for restrictive interventions, Department of Health, 2014
- Mental Capacity Act, 2005
- Violence and aggression: short-term management in mental health, health and community settings, NICE, 2015
- LPT Prevention and Manag30.7ement of Aggression Policy, 2019
- LPT Rapid Tranquillisation Policy, 2018
- LPT Safe and Therapeutic Observation of Inpatients policy, 2015
- LPT Searching of Inpatients Policy (2016)
- Healthcare Building Note 03-01; Adult Acute Mental Health Units (2013).

- The British Institute for Human Rights www.bihr.org
- Delivering race equality in mental health www.doh.gov.uk
- LPT Guidelines For Rapid Control Of Acutely Disturbed Younger Patients (aged 12-18 years) , 2016
- Mental Health Data Set, restrictive intervention guidance (2019)
- Lincolnshire NHS Foundation Trust Seclusion Policy
- Northumberland Tyne and Wear Seclusion Policy
- Seclusion policy for Coventry and Warwickshire Trust
- Merseycare NHS Foundation Trust

Appendix 1

Training Requirements

Training Needs Analysis

Training topic:	Seclusion and Long Term Segregation included in MAPA training
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ✓ Role specific ☐ Personal development
Division(s) to which the training is applicable:	✓ Mental Health Directorate ✓ Community Health Services ☐ Enabling Services ✓ Families Young People Children& Learning Disability Services ☐ Hosted Services
Staff groups who require the training:	*Please specify…* *All clinical staff in direct patient care.*
Regularity of Update requirement:	Annually.
Who is responsible for delivery of this training?	PMA Training Team
Have resources been identified?	Yes
Has a training plan been agreed?	Yes
Where will completion of this training be recorded?	✓ ULearn ☐ Other (please specify)
How is this training going to be monitored?	Via the monthly Workforce Training report discussed at the Trust Positive and Safe Meeting.

Appendix 2

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	✓ ☐
Respond to different needs of different sectors of the population	✓ ☐
Work continuously to improve quality services and to minimise errors	✓ ☐
Support and value its staff	✓ ☐
Work together with others to ensure a seamless service for patients	✓ ☐
Help keep people healthy and work to reduce health inequalities	✓ ☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	✓ ☐

Appendix 3

Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Rachel Shaw/ Rob Kerr	Trust Positive & Safe Lead

Circulated to the following individuals for comment

Name	Designation
Tracy Ward	Trust Patient Safety Improvement Group
Heather Darlow/ Jenny Dolphin	Heads of Directorate Governance Teams
Samantha Roost/ Bob Lovegrove	Health and Safety Team
Sue Elcock/ Avinash Hiremath	Medical Director
Fabida Aria/ Rohit Gumbar	Associate Medical Directors
Laura Belshaw	Head of Nursing FYPC/LD
Zayad Saumtally/ Lou Evans	Deputy Heads of Nursing
Paul Howley/ Liz Compton, Jane Capes, Jane Martin, Emily Jarvis, Jodhun Persand, Bernadette Cawley-Nash	Matrons
Members of the Legislative Committee	Corporate Governance Group
Members of the Positive and Safe Group	Corporate Governance Group
Greg Payne	Clinical Training Lead/ MAPA
Dean Cessford	Safeguarding Lead
Alison Wheelton	MHA Lead

Appendix 4

Due Regard Screening Template

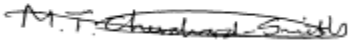
Section 1	
Name of activity/proposal	Seclusion of inpatients
Date Screening commenced	August 2020
Directorate / Service carrying out the Assessment	Adult Mental Health and Learning Disability Division
Name and role of person undertaking this Due Regard (Equality Analysis)	Michelle Churchard-Smith, AMH/LD Head of Nursing
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The aim of the seclusion policy is to provide staff within the Leicestershire Partnership NHS Trust with clear directives in the use of seclusion. The policy applies to all mental health and learning disability areas where seclusion is used.	
OBJECTIVES: De-escalation will be the first response, and only when the patient has not responded to alternative strategies will consideration be given to the use of seclusion. The use of seclusion must be safe, reasonable and justifiable in order that it minimises distress to the individual and strives to maintain dignity. Its use must only be in order to preserve safety and enable a reduction in risk to others.	
PURPOSE: To provide clear guidelines and standards for staff to work within.	

Section 2		
Protected Characteristic	**Could the proposal have a positive impact Yes or No (give details)**	**Could the proposal have a negative impact Yes or No (give details)**
Age Disability Gender reassignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion and Belief Sex Sexual Orientation Other equality groups?	Measures in place throughout this policy ensure that respect for the dignity of patients, carers and service users is maintained during the application of this policy (see section 1 , general principles, section 16, care planning to protect patients' rights and meet individual needs, section 19, post-seclusion review and Appendix 4, Due Regard).	

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		**No ✓**	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	

Section 4
It this proposal is low risk please give evidence or justification for how you reached this decision:
Throughout the development of this policy, careful consideration has been given to ensure that respect for the dignity of patients, carers and service users is maintained. See for example: – Section 1, general principles – Section 16, care planning to protect patients' rights and meet individual needs – Section 19, post-seclusion review – Appendix 4, Due Regard These considerations should be set in the context of a high risk activity where patient safety is paramount.

Sign off that this proposal is low risk and does not require a full Equality Analysis:

Head of Service Signed: 
Date: October 2020

Appendix 5

PRIVACY IMPACT ASSESSMENT SCREENING

Privacy impact assessment (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment.

The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Seclusion and Long Term Segregation Policy**		
Completed by:	**Michelle Churchard-Smith**		
Job title:	**AMH/LD Head of Nursing**	**Date**	**17 May 2019**

	Yes / No
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	**No**
2. Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document.	**No**
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	**No**
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**No**
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	**No**
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	**No**
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	**No**
8. Will the process require you to contact individuals in ways which they may find intrusive?	**No**

If the answer to any of these questions is 'Yes' please contact the Head of Data Privacy
Tel: 0116 2950997 Mobile: 07825 947786
Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, adoption of a procedural document will not take place until approved by the Head of Data Privacy.

IG Manager approval name:	**Samantha Kirkland**
Date of approval:	

Acknowledgement: Princess Alexandra Hospital NHS Trust