Leicestershire Partnership NHS Trust

# Seclusion & long-term segregation Policy

This policy provides staff within Leicestershire Partnerships NHS Trust with clear direction and process for the use of seclusion and long-term segregation in adults and children. This policy is applicable to inpatients staff working in DMH & FYPC/LDA.

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**Type of Policy**: Clinical

**Keywords**: Seclusion, Restrictive Practice, Long-term Segregation, Isolation, Confinement, Low Stimulus

# Contents

## i. Policy On a Page

**Aim and purpose**

The Seclusion and Long-Term Segregation Policy standardises the process for the use of seclusion and / or long-term segregation to safely manage significant risks of patients within inpatients services escorting inpatients within the Directorate of Mental Health (DMH) and Families, Young Persons & Children / Learning Disabilities & Autism (FYPC/LDA) services.

**Key systems and processes**

**Who Can Be Secluded?**

- Inpatients showing violent/aggressive behaviour unmanageable in an open ward.
- Only as a last resort after all de-escalation attempts fail.
- Patient must be detained under the Mental Health Act (MHA); otherwise escalate to consultant.

**What Counts as Seclusion?**

- Patient locked in a Trust-approved seclusion room or any room.
- Patient isolated and prevented from leaving by door or staff.
- Includes situations after physical interventions and verbal de-escalation.
- Extra care with staff also counts as seclusion.

**Key Procedures**

- **Initiation:** Nurse in charge or responsible clinician/duty doctor.
- **At Start:** Search patient, body map, physical health check, complete care plan, inform next of kin.
- **Termination:** As soon as possible, within or outside review.

**Reviews**

- Within 1 hour if doctor not involved initially.
- Every 2 hours until reduced.
- Reviews include mental/physical health, medication, hydration/nutrition, and less restrictive options.
- Escalate if unable to review after two attempts.

**Observations**

- Done by trained staff; qualified nurse for first hour and once per shift.
- Level 3 observations every 15 minutes (mental and physical state).
- Use CCTV only as support, not replacement.

**Patient Care**

- Protect privacy (blurred CCTV for toilet use).
- Support hygiene and dignity during reviews.
- Risk-assess for the use of feminine hygiene products.
- Self-harm risk: seclusion not for self-harm management; use anti-rip clothing if needed.

**Post-Seclusion Tasks**

- Post-seclusion review and body map.
- Clean and prepare room.
- Update risk assessment.
- Submit for the Ward Leader and Matron review.

**Expected outcomes:**

The policy aims to ensure safe, dignified, timely, collaborative, and person-centred care during the use of seclusion and / long-term segregation, as well as safeguarding both patients and staff while maintaining continuity of care.

**Policy on a Page – Long-Term Segregation (LTS)**

**Purpose:**

To manage patients who pose a **constant and severe risk to others**, where short-term measures (e.g., seclusion) are insufficient.

**Definition**

Long-Term Segregation means a patient is **prevented from mixing freely with other patients for an extended period**, while maintaining contact with staff and therapeutic engagement.

*(Mental Health Act Code of Practice, 2015)*

**When to Use**

- Risk to others is **continuous and cannot be reduced by short-term interventions**.
- Decision is **planned and agreed by MDT**, with family/carer and commissioner involvement.
- Only in environments that meet LTS requirements (bedroom, bathroom, lounge, secure outdoor area).

**Key Principles**

- **Least restrictive**, most homely environment possible.
- Maintain **privacy, dignity, cultural and spiritual needs**.
- Continuous **staff observation and engagement**.
- Document rationale and care plan in EPR.
- Notify **Safeguarding Team** and complete eIRF.

**Process Overview**

**Commencement:**

- MDT meeting with RC, family/carer/IMHA, commissioner.
- Complete care plan, body map, eIRF.
- Outline steps to end LTS.

**Reviews:**

- **Daily:** Approved clinician or ward doctor (discuss with RC).
- **Weekly:** Full MDT review.
- **Monthly:** Senior manager review; commissioners informed.
- **3-Monthly:** External hospital review with commissioner and IMHA.
- All reviews documented on EPR and Appendix 22 forms.

**Safeguards:**

- Hourly therapeutic observations.
- Access to food, fluids, hygiene, therapeutic activities.
- Regular risk assessment and plan to end LTS.

**Termination:**

- MDT decision following risk reduction.
- Complete termination checklist and update care plan.

**Special Considerations**

- **LD/Autism:** Escalate any LTS >48 hrs to Discharge Hub and NHS England; IC(E)TR reviews required.
- **Human Rights:** Ensure proportionality, dignity, and clear time-bound plan to end segregation.

## ii. 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.

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 advances 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, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area. This applies to all the activities for which LPT is responsible, including policy development, review, and implementation

If you would like any public Trust Policy in an accessible format, please email: lpt.corporateaffairs@nhs.net .

## iii. Due Regard

The Trust's commitment to equality means that this policy has been screened in relation to paying due regard to the general duty of the Equality Act 2010 to eliminate unlawful discrimination, harassment, and victimisation; advance equality of opportunity and foster good relations.

Measures in place throughout this policy ensure the respect the dignity of patients, carers and service users is maintained during the application of this policy (please refer to the Trust Equality, Diversity and Human Rights Policy available on the intranet).

To mitigate any adverse impact on relevant protected characteristics, the following examples can be provided:

- Interpretation and translation services are available to ensure all service users receive up to date relevant accessible reference to accessible format, alternative languages etc.

- Religion and belief are recognised in the policy as an essential criterion to ensure dignity, respect and cultural competency is assured. Please refer to the NHS Staff resource

- Training and development of staff applying this policy will ensure equality diversity and human rights is mainstreamed as an essential learning and development requirement.

- In addition to the examples highlighted above, equality monitoring of all relevant protected characteristics to whom the policy applies will be undertaken. Robust actions to reduce, mitigate and where possible remove any adverse impact will be agreed and effectively monitored.

This policy will be continually reviewed to ensure any inequality of opportunity for service users, patients, carers, and staff is eliminated wherever possible.

For further information, please refer to due regard assessment (Appendix 5) of this policy.

## iv. Policy Dissemination

This policy will be disseminated into all inpatient areas, it will be posted on the Internet and LPT Intranet (in accordance with the Freedom of Information Act) and communication of their existence will be via management structures and the Heads of Nursing/Operational Leads / Matrons. All LPT Policies can be provided in large print or Braille formats, if requested, and an interpreting service is available to individuals of different nationalities who require them. Did you print this document yourself? Please be advised that the Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version.

## v. For further information contact

- **Jon-Paul Vivers**, Deputy Head of Nursing, Inpatients Acute, Forensic, Psychiatric Intensive Care & Rehab Inpatients Services, DMH

- **Simon Guild**, Deputy Head of Nursing, Mental Health Services for Older Persons (Inpatients & Community), DMH

- **Rebecca Fowler and Melissa Parry**, Deputy Heads of Nursing, Families, Young Persons, Children / Learning Disabilities & Autism

# 1. Purpose of the Policy

1.1. Leicestershire Partnership (NHS) Trust (LPT)'s Seclusion and Long-Term Segregation Policy has been developed to ensure the safety and well-being of patients and staff within the Directorate of Mental Health (DMH) & the Families, Young Persons & Children / Learning Disabilities & Autism (FYPC/LDA) services where the use of seclusion and / long-term segregation is required for the management of significantly risky behaviours of patients within mental health inpatients services.

1.2. This policy has been developed in accordance with the NICE Guidelines (2015) *Violence and aggression: short-term management in mental health, health and community settings*, as well as 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, NHS England's guidance on reducing restrictive practices (2025)

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 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. (Human Rights Framework for Restraint, EHRC, 2019 and Equality Act 2010)

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 Services for Older People (MHSOP) do not have seclusion facilities. In exceptional circumstances where the risk is too high collaboration with Adult Inpatient 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. Aim of the Policy

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. 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, Mental Health Units (Use of Force) Act 2018, (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 services as a 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. Policy Requirements and Objectives

4.1. The overarching principle of the policy is to ensure that patients' need for the use of seclusion and / or long-term segregation to manage significant and immediate ongoing risks is assessed and considered including requirements to maintain the safety of the patient, other patients and the within mental health inpatients services.

4.2. The policy also aims to set out the roles and responsibilities of the patient's immediate and wider care team and how teams will work together to ensure the delivery of dignified, timely and effective care during the period of seclusion and / or long-term segregation.

4.3. This policy document is therefore linked to and guided by the following Care Quality Commission (CQC) Standards:

| CQC Standard | Performance Indicators |
|---|---|
| **Regulation 9**: Person-centred care | The care and treatment of service users must be appropriate, meet their needs and reflect their preferences, including the involvement of their family / carers (where indicated) |
| **Regulation 10**: Dignity and respect | Service users must be treated with dignity and respect |
| **Regulation 11**: Need for consent | Care and treatment must only be provided with the consent of the relevant person |
| **Regulation 12**: Safe care and treatment | Care and treatment must be provided in a safe way for service users |
| **Regulation 13**: Safeguarding service users from abuse and improper treatment | Service users must be protected from abuse and improper treatment |
| **Regulation 14**: Meeting nutritional and hydration needs | The nutritional and hydration needs of service users must be met, taking into consideration their cultural and religious requirements |
| **Regulation 15**: Premises and equipment | All premises and equipment used by the service provider must be clean, secure, suitable for the purpose, for which they are being use, properly used, maintained and appropriately located for the purpose for which they are being used |
| **Regulation 16**: Receiving and acting on complaints | Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation |
| **Regulation 17**: Good governance | Systems or processes must be established and operated effectively to ensure compliance with these regulations and effective mechanisms in place to support timely escalations of concerns (e.g., via the use of the Ulyssess' Electronic Incident Reporting Forms (eIRF) system). |
| **Regulation 17**: Fit and proper persons employed | Persons employed must be of good character, have the relevant qualifications, competence, skills and experience |

# 5. Roles and Responsibilities

## 5.1. Executive Management 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 service line Quality and Safety Groups, from the Least Restrictive Practice Group

## 5.2. Lead Executive Director

- Ensures services within the directorate are supported to implement the policy within local areas

## 5.3. Divisional Directors and Heads of Service

- Ensure that staff working within their services all understand and adhere to the Policy and associated local SOPs and guidance documents Page
- Agree to and approve associated local SOPs and guidance documents that support adoption and implementation of this Policy
- Review relevant Key Performance Indicators (KPIs) in relation to patient safety incidents involving escort duties and ensure compliance with national and local directives.

## 5.4. Governance Group level 1 and 2

- The Trustwide Least Restrictive Practice 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 Safety Forum.

## 5.5. Policy Team

- Define clear and expected standards of the Policy that promote LPT's values
- Provide advice and guidance on complex and / or sensitive topics in relation to the Policy
- Support LPT to meet its legal and regulatory obligations and requirements and which ensure the provision of safe care for patients and staff safety, as well as reduce risks by promoting safe working practices

## 5.6. Policy Authors

- Consult with all relevant stakeholders (including those external to LPT) to ensure inclusion of pertinent considerations and factors
- Undertaken timely and regular revisions to the Policy in line with expected organisational documentation standards, goals, and stated overall strategic objectives
- Ensure the circulation of the revised Policy to all relevant stakeholders and services

## 5.7. Operational leads (including Service Managers and Team Managers)

- Ensure timely dissemination of the Policy (as well as relevant documents / guidelines) to team leads of individual services / teams.
- Escalate any concerns / incidents in relation to the escort duty to Divisional Directors and Heads of Service

## 5.8. The Responsible Clinician (and Duty Doctor)

- 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.
- Continue 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 review, medical reviews can be reduced to 8 hourly, if this is thought appropriate and this decision should be documented in the progress notes and in the seclusion care plan. If this is not documented, the medical reviews should continue every 4 hours.
- 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
    - 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

## 5.9. All Staff

### 5.9.1. Ward Sisters / Charge Nurses (and their Deputies)

- Ensure that all staff are suitably trained and up to date in the use of seclusion, segregation, de-escalation and Physical intervention skills (Safety Interventions) and work to achieve policy standards and have completed the relevant competency.
- Ensure staff are fulfilling their responsibilities and where staff are found to be breaching this, the Trust will manage this through the supporting performance procedure

- Ensure that an eIRF is produced following each use of seclusion or segregation.
- Ensure that seclusion or Long-Term Segregation records are accurately maintained, and the information is produced as requested by managers.
- Review practice in their area on a monthly basis to monitor policy compliance and report on this to the Least Restrictive Practice Group.
- Address any discrepancies or issues for practice identified during monthly review, and report immediately to the operational manager or matron.
- Undertake a quality check to assure the accuracy of MDT documentation for each seclusion episode.
- 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 have the following responsibilities

### 5.9.2. Matrons

- Ensure that seclusion is being used appropriately within their area of responsibility.
- Ensure that quality check has been completed by Ward Sister/Charge Nurse.
- Identify any themes or trends regarding seclusion.
- Provide oversight and support for seclusion and segregation within their area of responsibility.
- Be involved in the clinical decision making surrounding extended use of seclusion.
- Escalate any concerns about the use of seclusion or Long-Term Segregation to Deputy Head of Nursing or Head of Nursing

### 5.9.3. Clinical Duty Manager (CDM) / Duty Coordinator / Nurse-in-Charge (for areas without a clinical duty coordinator / manager)

- Undertake regular checks across all inpatient settings over the 24-hour period to ensure that staff are fulfilling their roles and responsibilities.
- 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 Coordinator / 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

### 5.9.3. The Nurse-in-Charge (of the shift)

- All the duties of the ward staff highlighted below, as well as to:
- 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.
- 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

### 5.9.4. Ward Clinical Staff

The Ward clinical staff will:

- 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 Physical Intervention skills.
- Consider approaches to de-escalation of violence in accordance with the Restrictive Practices Policy and Safety Interventions training and exhaust all alternative less restrictive options prior to the use of seclusion or segregation.
- 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.
- Undertake observations 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).
- Ensure that everything required for a direct review is available in a timely manner, e.g. food & fluids, medications, staff required to enter.
- Complete all required documentation and report each incident of seclusion on an electronic incident report form (eIRF).
- Ensure that care plans are tailored for managing disturbed behaviour and are reviewed following an episode of seclusion.
- Liaise closely with medical colleagues and inform them of physical health concerns or prolonged restraint.

- 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 nurse in charge or Matron, and to complete an Incident Report Form.

### 5.9.5. The Clinical Trainers, Safeguarding Team, Least Restrictive Practice Leads

- Ensure the provision of high-quality training in the use of de-escalation and Physical Intervention skills.
- Safeguarding team / Least Restrictive Practice Leads 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

# 6. Process

## 6.1. Definition and use of Seclusion

6.1.1. 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).

6.1.2. 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).

6.1.3. 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 of *Violence and aggression: short-term management in mental health, health and community settings* (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).

6.1.4. 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.

6.1.5. Seclusion must not be used as:

- Punishment or threat
- Part of a treatment programme (although it may feature in a patient's advance statement of wishes)
- To manage workforce acuity / staff shortages
- Where it will exacerbate the risk of suicide
- 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)

6.1.6. 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

## 6.2. Seclusion in a non-ward area prior inpatient admission (the Place of Safety Assessment Unit)

6.2.1. In some circumstances, in the Place of Safety Assessment Unit, it may be necessary to shut the door to restrict the patient's access to leave the room due to a risk and / or safety incident. In these circumstances, all the same safeguards in relation to the use of seclusion should apply, including the documentation and review of the patient's presentation throughout this process.

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

## 6.3. The following practice should not be recorded as seclusion:

6.3.1. If a patient is being restrained by staff, they are not being secluded.

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

## 6.4. Children and young people under 18

6.4.1. 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

6.4.2. 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.

6.4.3. 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).

6.4.4. 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)

## 6.5. Seclusion rooms

6.5.1. 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 the 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.

6.5.2. 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.

6.5.3. 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 nighttime

- 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.

- Rooms should have access to toilet and washing facilities.

- Rooms should have no apparent safety hazards

6.5.4. The Trust completes an annual review of seclusion facilities against these standards.

6.5.5. Where seclusion rooms do not have ensuite toileting facilities, a risk assessment will be undertaken to identify the appropriateness of the patient using the nearest toilet. If this is not possible, they will be provided with bed pans. Staff should ensure all efforts are taken to maintain privacy and dignity accordingly. 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.

6.5.6. There should be access to female hygiene products and toilet paper unless an individual risk assessment indicates this would be potentially harmful.

6.5.7. 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.

6.5.8. 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.

6.5.9. 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.

6.5.10. 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

## 6.6. Wards that do not have seclusion facilities

6.6.1. 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.

6.6.2. 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.

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

6.6.4. 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.

6.6.5. 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 above

## 6.7. Decision to seclude

6.7.1. 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 and should have been involved in any de- escalation strategies.

6.7.2. 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.

6.7.3. 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.

6.7.4. The nurse in charge of the ward is responsible for ensuring that the seclusion recording sheet is completed contemporaneously (see Appendix 8). Accuracy of completion will be routinely reviewed as part of the enhanced seclusion review.

6.7.5. 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.

6.7.6. The first hour of 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 in line with the Trust's Rapid Tranquilisation policy.

6.7.7. All patients who have been secluded/placed in Long Term Segregation, will have their Next of Kin notified as soon as practicably possible, unless explicitly stated that they do not wish us to share information.

6.7.8. 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

## 6.8. Assessing the Risk

6.8.1. 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.

6.8.2. 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.

6.8.3. 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.

6.8.4. 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.

6.8.5. 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.

6.8.6. The attending doctor needs to be made aware of any physical conditions and injuries. As part of their documentation, the doctor must reference their physical assessment and any actions taken. A body map (Appendix 9) needs to be completed by the nurse at the commencement of seclusion, and this should show whether there are injuries or not at the point of seclusion.

6.8.7. If a patient is subject to prolonged restraint (over 10 minutes) 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.

6.8.8. 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.

6.8.9. 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.

## 6.9. Rapid tranquillisation

6.9.1. 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

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

## 6.10. Reviewing seclusion

6.10.1. 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 6.12 below. The patient must be informed that reviews will take place.

6.10.2. It is expected that all reviews are conducted by entering the seclusion room, unless in extreme circumstances, where there is evidence that this would pose an unacceptable level of risk. If the team have been unable to enter for more than one agreed review, then this need to be escalated. In hours, to Matron and Deputy Heads of Nursing. Out of hours, to on call manager and on-call consultant and a plan made as to how the review will be conducted to ensure that the patient has access to food and fluids and being reviewed.

6.10.3. The review must focus on:

- The condition and behaviour of the patient and whether the continued use of seclusion is appropriate and proportionate (for seclusion to continue, the patient's behaviours must be such that they present an immediate and significant risk to others)
- A review of the patient's physical and psychiatric health
- An assessment of the adverse effects of medication
- A reassessment of the medications prescribed
- An assessment of risk posed by the patient to others
- An assessment of risk to the patient from deliberate or accidental self- harm

- A statement of clinical needs (including any physical or mental health problems) risks and treatment objectives
- A plan as to how these needs will be met, how de-escalation attempts will continue and how risks will be managed
- Details of bedding and clothing to be provided
- Details as to how the patient's dietary needs are to be provided for
- Details of any family or carer contact/communication which will be maintained during the periods of seclusion in accordance with 26.16 Code of Practice.
- Details of any reasonable adjustment
- 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.
- Ensure the patient is safe.

6.10.4. There is an expectation that physical observations are undertaken at every review to ensure there are no physical health concerns which require review / medical review. Physical health reviews will 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. However, as a minimum, respirations should always be completed

6.10.5. 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 is being given, cleaning and providing fresh drinks/food. During a review, there should be attention paid to the amount of people present, to ensure it is not overwhelming or intimidating for the patient.

6.10.6. 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.

6.10.7. 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)

6.10.8. 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.

6.10.9. The nurse in charge of the ward is responsible for ensuring the completion of the seclusion observation recording (Appendix 12)

## 6.11. Seclusion Reviews

6.11.1. Seclusion Reviews must be documented using the Review Sheet (Appendix 12) to capture the names, designations and signatures of those in attendance. An entry should be completed within the Electronic Patient Record using the proforma identified (Appendix 18).

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

6.11.3. Review schedules follow MHA Code of Practice (2015) and NHS England's culture of care standards (2025)

## 6.12. Seclusion Review Timetable

6.12.1. Example: Seclusion commenced at 19:12

- First Nursing review – 21:12
- Second Review – 23:12
- Third Review – 01:12
- Fourth Review – 03:12
- Fifth Review – 05:12

6.12.2. 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 Deputy Head of Nursing and the Medical Lead and further dispute should be referred to the Head of Nursing and Clinical Director.

6.12.3. Where appropriate and necessary, the Least Restrictive Practice Practitioner/Clinical Trainers and Safeguarding Team must be involved in reviews and discussions about future management of patients in prolonged seclusion

## 6.13. Nursing Review

6.13.1. 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 escalated to the Clinical Duty Manager/Nurse in Charge or Matron and documented on the 'Review of Seclusion'.

6.13.2. 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.

## 6.14. Medical Review

6.14.1. 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.

6.14.2. If seclusion is to continue the clinical team should agree a seclusion care plan guidance (Appendix 11), which, although not exhaustive, outlines the main issues to consider when developing a seclusion care plan (Appendix 10).

6.14.3. 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).

6.14.4. 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.

6.14.5. 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 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
- 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

## 6.15. Senior Clinical Input in Seclusion Review

6.15.1. It is expected that all episodes of seclusion have clinical oversight at a senior level. This should include senior clinicians being involved in the reviews of patients in seclusion. These should occur as follows:

- A Matron should attend a review within four hours during working hours.

- Out of hours, it is expected that they attend the first review within hours if the patient remains in seclusion.
- Deputy Head of Nursing should attend the next review available, if the patient is likely to remain in seclusion over 24 hours.
- Head of Nursing should attend a review if the patient remains in seclusion over 72 hours

## 6.16. Internal Multidisciplinary Team Review

6.16.1. 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. (See Guidance for Doctors – Appendix 25 for details on cover)

6.16.2. 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.

6.16.3. 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

6.16.4. 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.

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

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

## 6.17. Independent MDT review

6.17.1. 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.

6.17.2. 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. Independent Mental Health Advocates - 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).

6.17.3. 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.

6.17.4. 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

## 6.18. Sleeping Patients

6.18.1. 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.

6.18.2. If a decision is made not to go in and review a sleeping patient but the risk to others is still felt to be high, then seclusion may continue. The rationale for this must be explicitly documented and must be made in conjunction with the MDT and where not available, the Nurse in Charge/CDM/Coordinator All involved must be able to see evidence of breathing at all times.

6.18.3. After 6 hours of the patient sleeping, there must be a review conducted to decide whether to terminate the seclusion.

## 6.19. Observation

6.19.1. All patients in seclusion must be nursed on level 3 observations.

6.19.2. 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.

6.19.3. The use of CCTV can be used to aid observations but must not replace seclusion observations. 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 focused on the task of observation, and readily available within sight and sound of the seclusion room at all times. The CCTV cameras must maintain their patient's dignity in areas where there are toilets or shower facilities are and be blurred for this purpose. If there is a concern about the patient's behaviour in these areas, the observing staff should seek support and arrange a review of the patient.

6.19.4. 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 enter the seclusion room.

6.19.5. Seclusion observations should be documented on the observations sheet (Appendix 12) 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 observations 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, using non-contact approach. 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)

6.19.6. Where the patient has been administered Rapid Tranquilisation (RT), the monitoring of physical observations should apply in line with LPT's Rapid Tranquilisation Policy. It is good practice to monitor the patient's respiratory rates every 15minutes and if this cannot be completed, the rationale for this should be documented within the patient's seclusion observation charts.

6.19.7. The first hour of observations should be completed by a Registered Nurse and then at least 1 hour 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 reviews.

6.19.8. 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.

6.19.9. 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 safety intervention holding skills. The member of staff must be able to communicate with other members of staff and an emergency protocol must be in place

## 6.20. Extra Care

6.20.1. At any time in which a patient is locked alone in a room (traditional seclusion), the requirements for monitoring, regulation and recording should always be consistent with MHA CoP (2015)

6.20.2. At times when the patient has left the seclusion room but is restricted to the Extra Care Area (and the Unit standard level of autonomy has not been returned to the patient), they should continue to be subject to monitoring, review and recording consistent with guidance on traditional seclusion.

6.20.3. Extra care will often look like an area separate to other patients, that the patient is unable to leave but is nursed there with staff supporting them as opposed to staff being on the other side of the locked door.

6.20.4. There is the expectation that the reviews continue throughout this period and if this becomes an extended care plan, consideration should be made for amending the care plan to Long Term Segregation.

6.20.5. Extra Care Areas should be designated areas that the team know are safe to be used, with appropriate furnishing and ability for patient to sleep if required.

## 6.21. Care planning to protect patients' rights and meet individual needs

6.21.1. 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.

6.21.2. For a seclusion specific care plan, guidance can be found in Appendix 11. It must be clear that seclusion is not a therapeutic intervention and is only to be used in the management of extreme risk.

6.21.3. 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 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.

6.21.4. A record must be made on the Recording Sheet for Commencement of Seclusion (Appendix 8) that the patient has been informed of these rights and the relevant leaflet may be offered as appropriate.

6.21.5. The secluded patient's religious beliefs and practices should 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.

6.21.6. 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.

6.21.7. 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.

6.21.8. 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.

6.21.9. If individual risk assessment permits, access to 'fresh air' should be facilitated via the ward garden.

6.21.10. Consideration should be given to any activities that could be safely undertaken whilst the patient in seclusion and this will be based on individual risk assessment.

6.21.11. 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.

6.21.12. 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

## 6.22. Nutrition and hydration monitoring

6.22.1. Regular fluids and food will be provided, and they will be documented on the seclusion observation recording sheet, (Appendix 12). 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.

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

6.22.3. Where appropriate, we can consider the use of safe cutlery to allow patients to eat a variety of foods.

6.22.4. The patient placed in seclusion must be placed immediately on a food and fluid chart to ensure that they are offered adequate dietary intake and that there is a record of this

## 6.23. Mental Health Act Status

6.23.1. 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.

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

6.23.3. 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 DoLs Policy. Staff should seek advice from the Local Authority if there is any doubt.

6.23.4. 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.

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

## 6.24. Termination of seclusion

6.24.1. 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.

6.24.2. 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.

6.24.3. 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.

6.24.4. Termination of seclusion must occur as soon as possible and should immediately end when an 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.

6.24.5. 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.

6.24.6. In the event of a disagreement, an urgent multi-disciplinary team review must be arranged. 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.

6.24.7. 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.

6.24.8. 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.

## 6.25. Post seclusion review

6.25.1. 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. Following the post seclusion review, it may be necessary to other the patient extra support.

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

## 6.26. Record Keeping

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

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

- Completion of the Seclusion Recording Forms (Appendix 14)
- 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.

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

| Job role | Record-keeping responsibilities |
|---|---|
| **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.<br>• 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<br>• Completion of seclusion recording sheet – nurse signature every 15 minutes<br>• Completion of post-seclusion review<br>• Completion of electronic Incident Report Form (eIRF) |
| **Medical staff** | • Details of who undertook scheduled medical reviews, their assessment and a record of the patient's condition and recommendations<br>• Details of who undertook the independent MDT review, their assessment and a record of the patient's condition and recommendations<br>• Details of who undertook the scheduled MDT reviews, their assessment and a record of the patient's condition and recommendations<br>• 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** | • Review and sign off of Ward Sister/Charge Nurse's quality check |

*** Seclusion documentation will be scanned onto the patient's electronic record before the Matron has completed their quality check to ensure that is it available in a timely manner*

## 6.27. Long Term Segregation

6.27.1. 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).

6.27.2. Nursing or caring for a person in enforced isolation, excluding isolation to prevent the spread of infection, regardless of:

- Whether the procedures and requirements of the MHA code of practice 2015 for Long Term Segregation are met **AND / OR**
- the user of services has periods of interaction with staff and or peers

6.27.3. This long-term segregation procedure applies LPT Trust areas that can meet the environmental requirements of Long-Term Segregation.

6.27.4. 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).

6.27.5. 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.

6.27.6. 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.

6.27.7. 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.
- Short periods of de-escalation, extra care or seclusion would not reduce the risk of harm to others.

## 6.28. Notes on segregation:

6.28.1. 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.*

6.28.2. 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*.

## 6.29. Decision to Start Long Term Segregation

6.29.1. 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 Independent Mental Health Advocate (IMHA) in their absence), as well as the commissioner for the patient. The attendees of this meeting should be clearly documented.

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

6.29.3. 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 been met, but also, the steps that will occur to end the episode of Long-Term Segregation.

6.29.4. 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.

## 6.30. Provisions and safeguards

6.30.1. 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.

6.30.2. 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

6.30.3. 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.

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

## 6.31. Review of the need for long-term segregation

6.31.1. 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.

6.31.2. 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.

6.31.3. 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 resident 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.

6.31.4. 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.

6.31.5. 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.

6.31.6. Where Long Term Segregation continues for three months or longer, regular 3-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 24).

6.31.7. 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 22) 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.

6.31.8. 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.

6.31.9. Where appropriate, the Least Restrictive Practice Practitioner/Clinical Trainers and Safeguarding Team must be involved in reviews and discussions about the future management of patients in Long Term Segregation.

6.31.10. 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.

6.31.11. 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.

## 6.32. Procedure for Patients who are being cared for under Long Term Segregation Restrictions who require may require Seclusion

6.32.1. 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 been in a suite of rooms as described in Section 6.5 with staff observing them on constant therapeutic observations.

6.32.2. 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

6.32.3. 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.

6.32.4. 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.

6.32.5. 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.

6.32.6. 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.

6.32.7. 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.

6.32.8. 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.

6.32.9. 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.

6.32.10. The 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.

6.32.11. 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.

6.32.12. 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.

## 6.33. Monitoring the use of long-term segregation

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

6.33.2. The use of long-term segregation will also be monitored using a specific audit tool for Long term segregation.

## 6.34. Consideration for the use of enforced (self) isolation, seclusion and / or Long-Term Segregation for individuals with a diagnosis of Learning Disability and / or Autism (LD/A)

6.34.1. According to the Care Quality Commission (CQC)'s *Out of sight - who cares?: Restraint, segregation and seclusion* (2020) report, individuals with LD/A should be supported to live in the community. However, where care and treatment in hospital as inpatients is indicated, such individuals must receive "…high-quality, person-centred and specialised care…with attempts to reduce restrictive practice…", which includes regular Independent Care (Education) and Treatment Reviews (IC(E)TRs) meetings during any episode of the continued use of seclusion / LTS / enforced (self) isolation after 48hrs as part of person-centred Care Planning. *NHS England IC(E)TR guidance (2023), Baroness Hollins report (2023)*

6.34.2. Where individuals with a diagnosis of Learning Disability and / or Autism (LD/A) require the use of seclusion to temporarily manage significant risks, the recommended processes highlighted above should be adhered to, including timely (independent) reviews, risks assessments and clear documentation.

6.34.3. However, where the requirement for the continued use of seclusion / LTS / enforced (self) isolation after 48hrs is indicated, the individual's care team should immediately notify the Discharge Hub who will in turn notify NHS England (NHSE).

6.34.4. The ward will ensure the documentation of these cases using the Isolation documentation template (see Appendix 18) to continuously review and record the ongoing seclusion / LTS / enforced (self) isolation, including:

- Patient details
- Start date
- Rationale
- Individual's Awareness of the continued use of seclusion / LTS / enforced (self) isolation
- Involvement of family / IMHA
- Social contact plan
- MDT reviews
- IC(E)TR meetings / considerations.

6.34.5. IC(E)TRs are meetings aimed at improving the treatment of people with a learning disability or autistic people in long-term segregation and the revised IC(E)TR guidance (2023) clearly states that:

- **Any prolonged enforced isolation** (even if not legally defined as LTS or seclusion) **must be highlighted** and **addressed**.

- The focus should be on the **impact on the individual**.
- **Human rights considerations** must guide practice, with urgent escalation and review of such cases.
- Services must provide a **clear, time-bound plan** to end isolation, involving the person, their family, (independent) advocates, as well as with support from oversight bodies, from local governance groups within the organisation to external agencies such as the Commissioners and NHS England (where indicated).

6.34.6. The patient's inpatients care team should ensure any cases of the continued use of seclusion / LTS / enforced (self) isolation for over 48hrs are escalated with the same urgency as LTS, including clear plans for ending isolation and restoring meaningful contact at the earliest and safest opportunity available.

6.34.7. The service management / leads will include any instances of the continued use of seclusion / LTS / enforced (self) isolation for over 48hrs in the Least Restrictive Practice Group (LRPG) reviews with directorate highlight reports to identify themes and ensure learning is shared across services.

6.34.8. The patient's inpatient care team must ensure that enforced (self) isolation is documented in the patient's clinical record rather than logged as an eIRF. Seclusion and LTS episodes should continue to be reported via eIRFs on Ulysses under their respective categories for oversight.

## 7.0. Training

The Trust Safety Intervention training incorporates seclusion and segregation into their advanced and emergency training. There is also an eLearning seclusion training which is role essential for areas that provide seclusion.

Staff involved in seclusion or Long-Term Segregation must be suitably trained and up to date in the use of Safety Interventions physical holding skills Compliance for this can be measured for this using training records.

## 8.0. Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this Policy is delivered and clearly documented within the patients' SystmOne records accordingly. In the event of an emergency and / or where the patient is incapacitated and / or unable to provide consent, relevant policies and procedures around capacity should be consulted and reverted to in an MDT, to ensure that the patient is

provided with the most appropriate care and treatment in a timely manner, and this should clearly documented in the patient's electronic records on SystmOne.

## 9.0. Fraud, Bribery and Corruption Considerations

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trust's Local Counter-Fraud Specialist (LCFS) for assistance

## Appendix 1 References

| References and associated documents |
| --- |
| • Baroness Hollins Report (2023): My Heart Breaks – Solitary Confinement in Hospital<br>• Care Quality Commission (CQC)'s *Out of sight - who cares?: Restraint, segregation and seclusion* (2020)<br>• Delivering race equality in mental health www.doh.gov.uk<br>• Equality Act 2010 – Public Sector Equality Duty and protected characteristics guidance.<br>• Healthcare Building Note 03-01; Adult Acute Mental Health Units (2013).<br>• Human Rights Framework for Restraint (Equality and Human Rights Commission, 2019).<br>• Independent Care (Education) and Treatment Reviews (IC(E)TR) Guidance (NHS England, 2023)<br>• Lincolnshire NHS Foundation Trust Seclusion Policy<br>• LPT Incident/Serious Incident Reporting Policy, 2020<br>• LPT Rapid Tranquillisation Policy, 2022<br>• LPT Searching of Inpatients Policy and their property (2023)<br>• LPT Supportive Observation and Engagement of Inpatients Policy, 2024<br>• LPT Violence Prevention and Reduction Policy, 2024<br>• Mental Capacity Act, 2005<br>• Mental Health Act Code of Practice, 2015<br>• Mental Health Data Set, restrictive intervention guidance (2019)<br>• Mental Health Units (Use of Force) Act 2018 - Statutory Guidance (Department of Health and Social Care, 2021).<br>• 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 |

- NHS England (2025). Identifying Restrictive Practice – Guidance for reducing restrictive practices in mental health inpatient services.
- NICE NG10: Violence and Aggression – Short-term Management in Mental Health, Health and Community Settings (2015).
- Northumberland Tyne and Wear Seclusion Policy
- Positive and Proactive Care: reducing the need for restrictive interventions, Department of Health, 2014
- Restraint Reduction Network Resources – Including guidance on blanket restrictions, psychological restraint, and environmental restraint.

## Appendix 2 Definitions

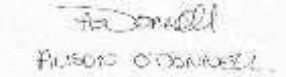
| Term | Definition |
|---|---|
| **Advance statement** | An advance statement is a way for a user of mental health or learning disability services to say how he or she would like to be treated in the future if they ever lost the ability to decide for themselves |
| **Approved Clinician** | A professional 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 |
| **Continuous Level of 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. 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. |
| **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. |
| **IC(E)TR** | Independent Care (Education) and Treatment Reviews (IC(E)TRs) are meetings intended to improve the treatment of people with a learning disability or autistic people in long-term segregation |
| **IMHA** | Independent Mental Health Advocate |

| | |
|---|---|
| **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 and NHS England's restrictive practice resource, 2025 ). |
| **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. |
| **Rapid Tranquilisation** | The use of injectable medication to control severe mental and behavioural disturbance, including aggression associated with mental illness |
| **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:<br>• 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.<br>• End or reduce significantly the danger to the person or others.<br>• Contain or limit the person's freedom for no longer is necessary"<br><br>• 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.'<br>• 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.'<br>• 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.'<br>• 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.'<br>See *Positive and Proactive Care: Reducing the need for restrictive interventions*, DoH. April 2014 |
| **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) |

| | |
|---|---|
| **Reviews** | 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. |
| **Safety Interventions** | CPI Safety Intervention training is the Trust approved training for supporting patients in crisis, which delivers a range of techniques to staff to maintain their safety and the safety of the patients when exhibiting risk behaviours. It works through the Crisis Development model and includes skills where staff may use physical interventions to intervene. This training has been approved by the Restraint Reduction Network. |
| **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). |

## Appendix 3 Training Needs Analysis

Training required to meet the policy requirements must be approved prior to policy approval. Learning and Development manage the approval of training. Send this form to lpt.tel@nhs.net for review.

| | | | |
|---|---|---|---|
| **Training topic/title:** | Safety Interventions and Seclusion eLearning and competency assessment | | |
| Type of training:<br>(see Mandatory and Role Essential Training policy for descriptions) | ☐ Not required<br>☐ Mandatory (must be on mandatory training register)<br>☐ Role Essential (must be on the role essential training register)<br>☐ Desirable or Developmental | | |
| Directorate to which the training is applicable: | ☐ Directorate of Mental Health<br>☐ Community Health Services<br>☐ Enabling Services<br>☐ Estates and Facilities<br>☐ Families, Young People, Children, Learning Disability and Autism<br>☐ Hosted Services | | |
| Staff groups who require the training: (consider bank /agency/volunteers/medical) | *All nursing (registered and non-registered) staff working within inpatients and select Urgent Care pathway services* | | |
| Governance group who has approved this training: | Least Restrictive | Date approved: | March 2025 |
| Named lead or team who is responsible for this training: | LPT Learning & Development Team | | |
| Delivery mode of training: eLearning/virtual/classroom/ informal/ad hoc | LPT Learning & Development Team | | |
| Has a training plan been agreed? | Yes | | |
| Where will completion of this training be recorded? | ☐ uLearn<br>☐ Other (please specify) | | |
| How is this training going to be quality assured and completions monitored? | Monthly workforce reports;<br>Compliance monitored within both clinical directorates | | |
| **Signed by Learning and Development Approval name and date** |  | Date: March 2025 | |

## Appendix 4 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.

**Answer (☐ Yes / ☐ No) to all as applicable:**

1. Shape its services around the needs and preferences of individual patients, their families and their carers (☐ Yes / ☐ No)

2. Respond to different needs of different sectors of the population (☐ Yes / ☐ No)

3. Work continuously to improve quality services and to minimise errors yes/no Support and value its staff (☐ Yes / ☐ No)

4. Work together with others to ensure a seamless service for patients yes/no Help keep people healthy and work to reduce health inequalities (☐ Yes / ☐ No)

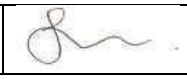
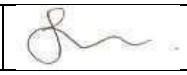
5. Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance (☐ Yes / ☐ No)

## Appendix 5 Due Regard Screening Template

| **Section 1** | |
|---|---|
| **Name of activity/proposal** | Seclusion and Long-Term Segregation |
| **Date Screening commenced** | 17.01.2025 |
| **Directorate / Service carrying out the assessment** | Directorate of Mental Health |
| **Name and role of person undertaking this Due Regard (Equality Analysis)** | Saskya Falope – DMH Head of Nursing, AHPs and Quality |
| **Give an overview of the aims, objectives and purpose of the proposal:** | |
| **AIMS:**<br>The aim of this policy is to provide a framework to ensure the principles of safety, privacy, dignity and least restrictive practices are adhered to and safeguard patients and staff when they come into contact with Leicestershire Partnership NHS Trust during risk and safety incidents that might require management via the use of seclusion | |
| **OBJECTIVES:**<br>Patients under the care of Leicestershire Partnership NHS Trust are treated with privacy, dignity, respect, and using least-restrictive practices when in an acute mental health crisis to the point of requiring short-term management within seclusion. | |

| **Section 2** | |
|---|---|
| **Protected Characteristic** | **If the proposal/s have a positive or negative impact** *(please give brief details)* |
| Age | No Impacts |
| Disability | No Impacts |
| Gender reassignment | No Impacts |
| Marriage & Civil Partnership | No Impacts |
| Pregnancy & Maternity | No Impacts |
| Race | No Impacts |
| Religion and Belief | No Impacts |
| Sex | No Impacts |
| Sexual Orientation | No Impacts |
| Other equality groups? | No Impacts |

| **Section 3** | | | |
|---|---|---|---|
| **Does this activity propose major changes in terms of scale or significance for LPT?**<br>**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** | | | |
|---|---|---|---|
| **If this proposal is low risk, please give evidence or justification for how you reached this decision:** | | | |
| This policy has been developed with some minor amendments to clinical practice; there are no major changes in terms of scale or significance for LPT. | | | |
| **Signed by reviewer/assessor** |  | **Date** | 17.01.2025 |
| *Sign off that this proposal is low risk and does not require a full Equality Analysis* | | | |
| **Head of Service Signed** |  | **Date** | 17.01.2025 |

# Appendix 5 Data Privacy Impact Assessment Screening

**Data Privacy impact assessment (DPIAs) 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 following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**

| | | |
|---|---|---|
| **Name of Document:** | **LPT Seclusion and LTS Policy** | |
| **Completed by:** | **Saskya Falope** | |
| **Job title** | **Head of Nursing, AHP's & Quality** | **Date 17.05.2025** |

| **Screening Questions** | **Yes / No** | **Explanatory Note** |
|---|---|---|
| **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 them? 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 Data Privacy Team via Lpt-dataprivacy@nhs.net**

**In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**

| | |
|---|---|
| **Data Privacy approval name:** | N/A |
| **Date of approval** | N/A |

## Appendix 7 Seclusion Review Timetable

Appendix 7

**Seclusion Review Timetable**

Leicestershire Partnership NHS Trust

**Date Seclusion was initiated:**_____

**Time Seclusion was initiated :**_____

**Nursing Reviews (every 2 hours)**

| Time Due | Completed at (Time) | Next nursing review due at: (Time) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Medical Reviews (4 hourly until Internal MDT, then twice daily)**

| | Time Due | Time Completed | Next Medical Review Due: (Time) |
|---|---|---|---|
| **Initial Review** (within 1st hour if not involved in decision to seclude) | | | |
| **Medical Review** (4 hourly if MDT not occurred, then twice daily) | | | |
| **Matron Review** (within 4 hours in working hours or first review in hours) | | | |
| **Internal MDT** (As soon as practicable, once occurred, medical reviews can be twice daily) | | | |
| **Independent MDT** (after 8 hours or 12 hours intermittent) | | | |
| **Deputy Head of Nursing Review** (within 24 hours) | | | |
| **Head of Nursing Review** (within 72 hours) | | | |

# Appendix 8 Recording Sheet for the Commencement of Seclusion

Recording sheet for commencement of Seclusion
*All parts must be completed

| MHA Status | | eIRF No: | |
|---|---|---|---|

Patient Label

If informal patient, seek a senior medical review immediately

**People in attendance when decision was made to seclude:**

| Full Name | Designation |
|---|---|
| | [Person who made the decision to seclude] |
| | |
| | |
| | |
| | |
| | |

If a doctor was not involved in the decision to seclude a medical review needs to take place ASAP (within 1st hour). 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

| | | | |
|---|---|---|---|
| Date Seclusion Commenced: | | Time Seclusion Commenced | |
| Date Seclusion Terminated: | | Time Seclusion Terminated | |
| Total time in seclusion in hours and minutes | | Location of seclusion room | |
| | | Admitted Ward | |
| | | Was this the first time the patient has been in seclusion? | ☐ Yes ☐ No |

| | |
|---|---|
| Reason for Seclusion: | Does the patient have LD or Autism?<br>☐ Yes ☐ No (*if YES, continue to the next questions*) |
| What alternative risk management strategies were implemented: (*e.g. de-escalation, low stimulus, medication*): | Did the episode exceed over 48 hours?<br>☐ Yes ☐ No (*if YES, please inform the discharge hub*) |
| Identified Risk Issues: | Has the Discharge Hub been notified?<br>☐ Yes ☐ No (*if NO, state reasons*) |

Has the patient been informed of their rights in seclusion including as a minimum that a member of staff will be within sight and sound of the seclusion room at all times and they can call for assistance for toileting and other needs:

☐ Yes ☐ No (*if NO, state reasons*) PRINT STAFF NAME:

Patient Label

Leicestershire Partnership NHS Trust

| Physical Assessment | Yes* | No | Not known | Time |
|---|---|---|---|---|
| Have you been unable to get patient's vital signs prior to seclusion? | | | | |
| Does the patient have any known medical conditions? | | | | |
| Has the patient used alcohol | | | | |
| Has the patient recently used illicit substances? | | | | |
| Has rapid tranquillisation been used recently? | | | | |
| Is the patient currently heavily sedated? | | | | |
| Is there any specific monitoring required? (e.g. fluids/blood sugars) | | | | |
| Has the patient been subject to prolonged restraint?<br>*Please enter the length of time in hours and minutes* | | | | |

*Please give details if any of the answers above were 'Yes', advise the attending doctor and detail any special instructions/ observations:

Detail below medication administered (either regularly prescribed, PRN or rapid tranquillisation) administered prior to Seclusion:

| Medication | Dose | Time | Route |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Checking & Searching Patients:**

Has the patient been searched for hazardous objects in accordance with the Trust Searching Inpatients Policy? ☐ Yes ☐ No
If **No**, state why:

Has the reason for the search been explained? ☐ Yes ☐ No
If **No**, state why:

Patient Label

Leicestershire Partnership NHS Trust

**Clothing & Property:**

Is the patient wearing? ☐ Own Clothes ☐ Seclusion Wear

If patient is wearing seclusion clothing, please document why:

List all items (clothing and possessions) that patient has taken into the seclusion room:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

If personal belongings have been removed at the time of seclusion please list these and the name of the staff responsible for securing property and where it has been stored:

_____ _____

_____ _____

_____ _____

Print Staff Name:_____

If this is the first time patient has been in seclusion, complete care plan (Appendix 10)

Completed ☐ Print Staff Name:_____

If the patient has used seclusion as a tertiary intervention of their PBS/Collaborative Care plan, review the care plan to ensure that it evidences what interventions are required to support the termination of seclusion at the earliest opportunity.

Completed ☐ Print Staff Name:_____

**Person responsible for ensuring completion of this form:**

Name_____Signature_____Date_____

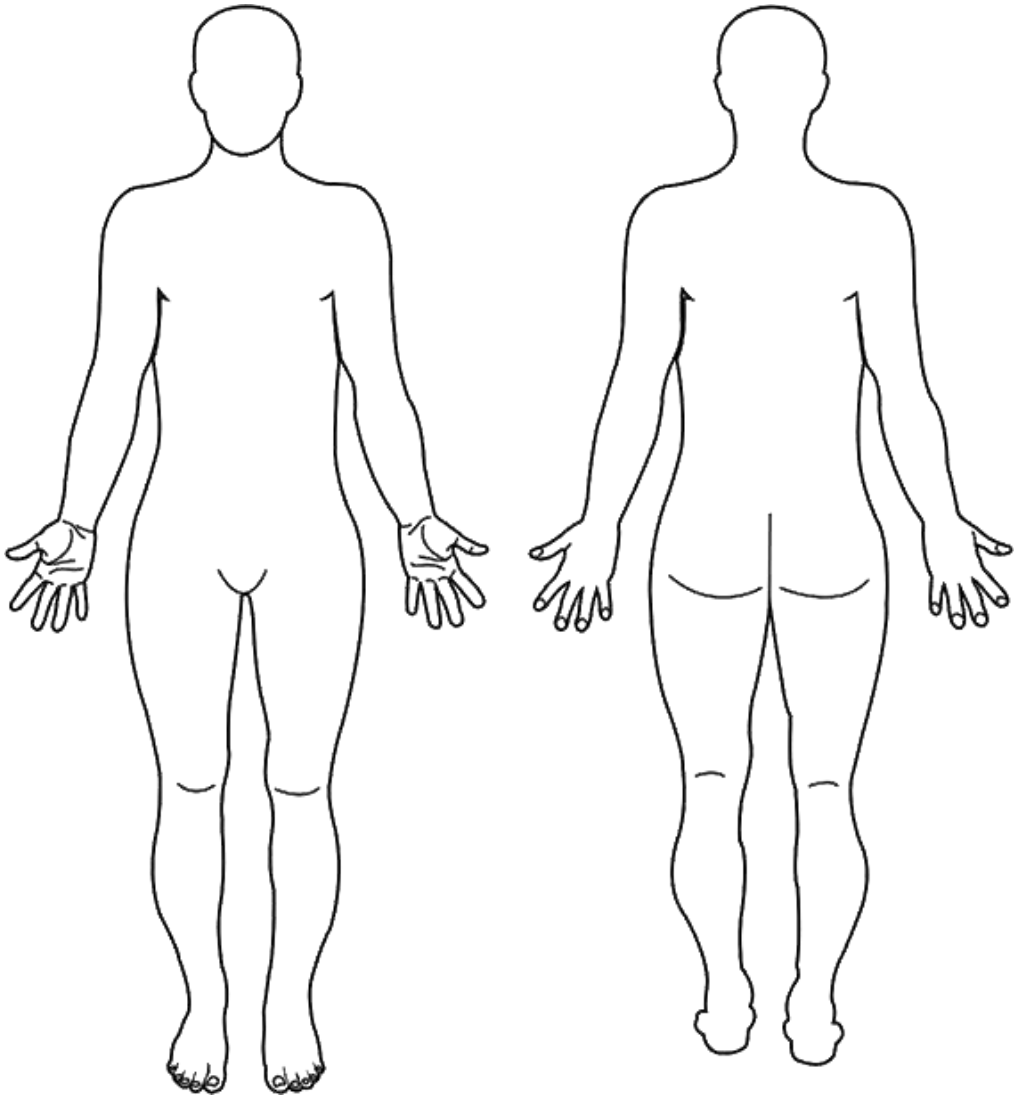
Patient Label

## Appendix 9 Seclusion Body Map

Body Map:

Draw on image and add a description of the marks/ injuries
Check the appropriate box below the purpose of the Body Map:

☐ Seclusion ☐ Commencement Long Term Segregation Termination



**FRONT** **BACK**

| |
|---|
| **Date:** |
| **Time:** |
| **Completed by (PRINT NAME IN FULL):** |

Patient Label

# Appendix 10 Seclusion Care Plan Template

| | |
|---|---|
| **Statement of clinical needs, risks, treatment objectives:** | |
| **How we will meet your needs:**<br>(To Include Diet, Hydration, Personal Hygiene and Toilet). | |
| **How we will continue to monitor/communicate/deescalate:**<br>(To include information re: observations and when reviews will take place) | |
| **How we will manage your risks:** | |
| **How we will monitor your physical health:** | |
| **How we will manage the items you have with you:**<br>(To Include Mattress, Seclusion Chair, Strong Clothing, Belongings) | |
| **How We Will Manage any other special requirements (e.g., Cultural needs):** | |
| Does patient have capacity to make the following decisions below: ☐ **Yes** ☐ **No**<br>(If **No**, complete SystmOne Capacity Assessment and contact NoK if in patient's best interests) | |
| i. Would you like us to contact your next of kin? | |
| ii. Would you like us to contact anybody else? | |
| iii. Would you like us to contact advocacy? | |
| What do you need to do for seclusion to come to an end? | |
| When seclusion comes to an end, this is what we will do?<br>(To be completed when decision is made to re-integrate to the ward environment) | |
| Patient Signature: | Date:_____ Time:_____ |
| Nurse's Signature: | Date:_____ Time:_____ |

# Appendix 11 Seclusion Care Planning Guidance

**SECLUSION CARE PLANNING GUIDANCE**

The purpose of this guidance is to support staff in the completion of a care plan for those in seclusion. Things to consider when completing the care plan:

- Access to religious materials or support while in seclusion (consideration to be given around religious festivals or significant dates).
- Regular discussion around the reasons for seclusion
- To be clear on what is required for the seclusion to be terminated
- Ensuring access to time/date for the patient.
- Ensure patient communication needs are supported.
- Ensuring process for sending and receiving communication from relatives/visitors.
- If there are times (washing access) for specific gender staff to be observing patient
- Meal times and preferences/requirements for dietary intake
- Clothing required (what can they have of their own, does it need to be seclusion clothing), also planning requirements for under garments and changing clothes. (during reviews).
- What bedding and other items will be available within the seclusion room.
- Access to activities (music, papers, books etc.) in line with potential risks against therapeutic support.
- Plan for reviews- e.g. Will patient be stood/sat/lying for team to enter the door, gender specific staff, observations being carried out, order of review i.e. physical obs first then mental state review

It may not be possible to give the patient a copy of the care plan in seclusion, but they should be given access to either read or have it read to them. Please ensure where a care plan is needed for seclusion a copy is in the seclusion area so the observing staff and patient can access it.

Seclusion can be traumatic for patients, and as such this care plan should aim to address any concerns the patient has while in seclusion.

The aim of a seclusion care plan is to maintain the safety and welfare of a patient in seclusion while also promoting recovery to a point where seclusion can be terminated, and the patient is no longer subject to this restriction.

## Appendix 12 Seclusion Observation Recording

**REGISTERED NURSING STAFF MUST COMPLETE THE FIRST HOUR OF OBSERVATIONS AND THEN 1 HOUR OF OBSERVATIONS PER 12 HOUR SHIFT**

Patient Label

**SECLUSION OBSERVATION RECORDING**

| **Date / time of entry** (24-hour clock) | **Observations** A documented report must be made at least every 15 minutes or more frequently if required. To note patients' behaviours, communication, mental state, respirations, food and fluids record amount offered and taken | **Name** (Print First and Surname) | **Signature** | **Designation** (Print) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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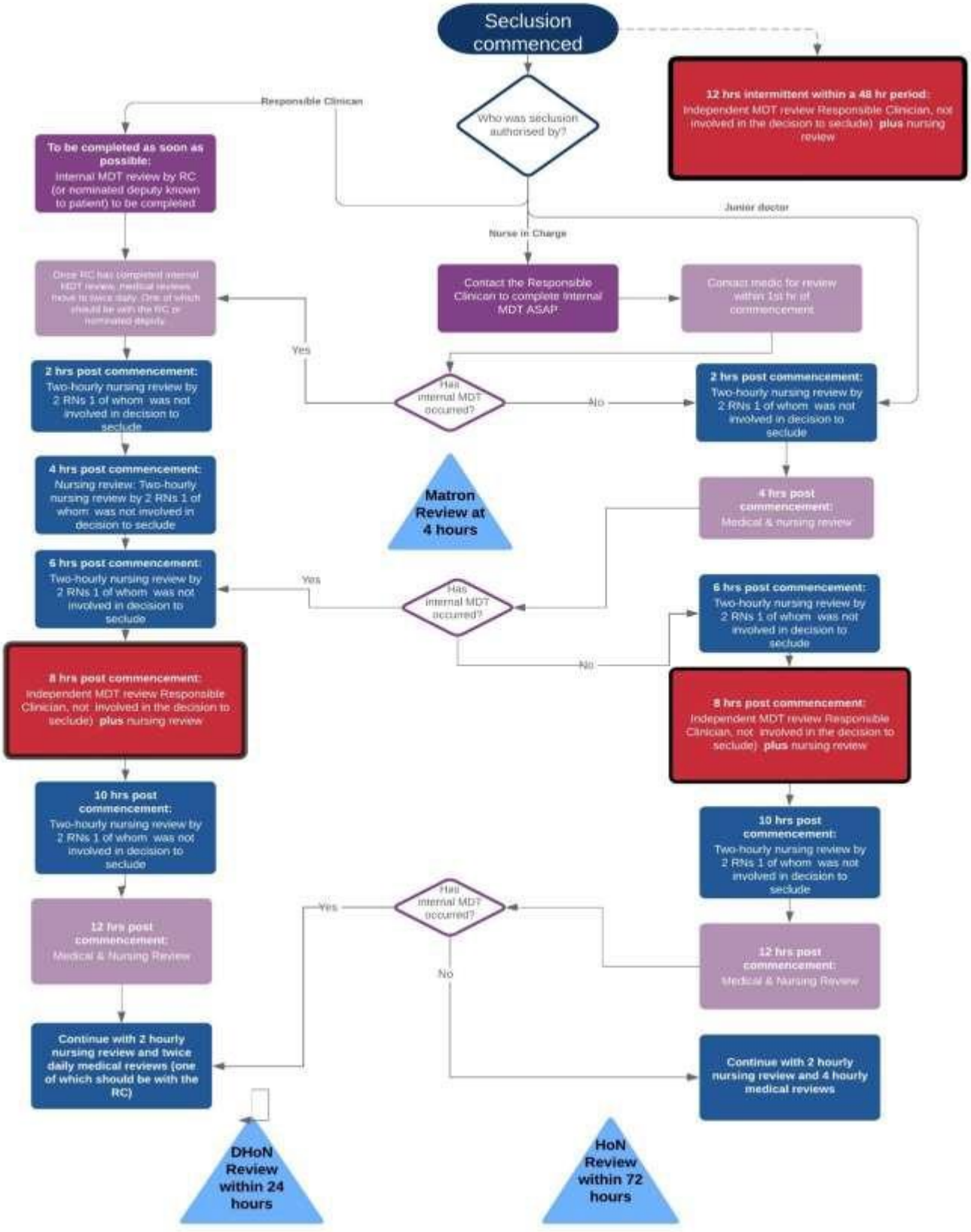
# Appendix 13 Seclusion Reviews Flowchart



## Appendix 14 Seclusion Record – Review Sheet

Patient Label

Review No…… of …….

| | | |
|---|---|---|
| Type of Review (Please Circle) | **Nursing**<br>Every 2 hours with 2 Qualified Nurses | **Medical**<br>Every 4 hours until internal review decides frequency (can be more often) |
| | **Internal MDT Review**<br>Patient's own RC or covering RC (Daily) | **Independent MDT Review**<br>Consultant who is not involved in the patient's care. Timescale for further independent reviews should be decided and documented by independent MDT. |

| | | | |
|---|---|---|---|
| **Date Of Review:** | / / | **Time of Review:** | (USE 24-HOUR CLOCK): |

| | |
|---|---|
| **Nurse in Charge**<br>Print Name and Designation | |
| **Signature** | |
| **2nd Qualified Nurse**<br>Print Name and Designation | |
| **Signature** | |
| **Doctor (where appropriate)**<br>Print Name and Designation | |
| **Signature** | |

**OTHER ATTENDEES**

| Print Name | Designation | Signature |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Appendix 15 Post Incident Review for Patients

This information should support record-keeping within the Patient's electronic records.

Nurse-in-Charge to complete the following sections:

Patient Label

Is patient awake for review? Yes ☐ No ☐

***If No, the decision to not wake for review must be made in conjunction with somebody independent from the ward and documented within patient's notes.

Is Seclusion to continue? Yes ☐ No ☐ If No, complete termination form.

Assessment and Rationale for Continuing Seclusion:

_____

_____

_____

Has the patient been informed of the decision? Yes ☐ No ☐

Have family member, carer and/or Advocate been informed of decision if applicable? Yes ☐ No ☐ N/A ☐

Food and Fluid—amount offered and taken

Hygiene—use of toilet/wash/shower

Medication:

| Physical Assessment **(AVPU & RR as minimum)** | AVPU | RR | Pulse | BP | SPO2 | Temp | Medical |
|---|---|---|---|---|---|---|---|
| Orientation—time, place, person | | | | | | | |

Check previous 2 hours of observations for completeness and the continuous observations support the need for ongoing seclusion ☐ Completed

Action taken to rectify if required:

Update the electronic Care Plan with the information gathered from the paper care plan and any other learning of how to support the patient when in crisis or escalating to the point of seclusion. Tick this box when complete ☐

Completed by:

Name:_____ Designation: _____

Signature:_____

# Appendix 15 Post Incident Review for Patients

**(Not to be uploaded to the patient's records)**

Patient Label

| Type of Incident (Please Circle) | Seclusion | Long Term Segregation |
|---|---|---|
| | Rapid Tranquilisation | High Risk Restraint |

What happened in the incident?

How do you feel about the incident

In your mind, what led to the incident?

Can you think of other ways this could have been resolved?

What other coping strategies/distraction/calm down methods/activities could we have helped you engage in to prevent this in future?

How do you feel about the way staff involved you during the incident? Is there anything else they could have done differently?

Care Plan Reviewed? Yes ☐ No ☐

If not complete, explain why?

Patient Signature:_____ Date:_____

Staff Name:_____ Staff Signature:_____

Charge Nurse/Sister Review:

Name_____ Signature_____ Date:_____

## Appendix 16 Seclusion Termination & Quality Checking

NOT TO BE UPLOADED TO THE PATIENT'S RECORDS

| | |
|---|---|
| **eIRF number** | |
| **Nurse responsible for termination of seclusion**<br>**[Print full name]** | |

Patient Label

| | **Sign when completed** |
|---|---|
| **Post seclusion body map completed** | |
| **Post seclusion review with patient** | |
| **Appropriate level of observations applied** | |
| **Seclusion room clean and checklist completed** | |
| **Risk Assessment & Care Plan updated** | |
| **Ensure all documents collated for Sister/Charge Nurse sign off** | |

| **Ward Sister/Charge Nurse**<br>**(or deputy in their absence)** | **Signature** | **Date** |
|---|---|---|
| | | |

**Tick that all following are complete:**

| | | | |
|---|---|---|---|
| Next of kin contacted where appropriate | ☐ | Care Plan completed | ☐ |
| Reviews occurred in line with flowchart | ☐ | Pre body map completed | ☐ |
| Reviews completed using proforma on EPR | ☐ | Post body map completed | ☐ |
| Check Signatures completed every 15 minutes | ☐ | Risk Assessment updated | ☐ |

**Once all of the above are completed, sign off the eIRF and complete weekly exception report and submit to your Matron for scrutiny**

| **Matron** | **Signature** | **Date** |
|---|---|---|
| | | |

**Complete Quality Check on AMAT**

## Appendix 17 Checklist for cleaning seclusion rooms

**NOT TO BE UPLOADED TO PATIENT RECORD**

| | |
|---|---|
| | Nurse in charge of the ward to ensure that the room is fit for purpose and check for any damage. Any repairs or maintenance must be reported immediately |
| | Check the mattress for any tears |
| | The room must be cleaned, and the seclusion mattress removed while the floor is washed |
| | Clean the mattress with Clinell wipes |
| | If there are bodily fluids, please use Chlorclean wipes for small spillages and for larger areas use Chlorclean tablets |
| | Check that the air- conditioning unit is working |
| | Check that the intercom is working |
| | Check all cameras, mirrors or viewing panels are clean |
| | Ensure that there is a clock in the area outside of seclusion, that it is working and clearly visible from the seclusion room |
| | Ensure that the floor is completely dry before returning the mattress to the room |
| | For seclusion rooms with integrated toilets, ensure that the toilet has been cleaned and is in working order |
| | Ensure that the room is free from any debris |
| | Monday- Friday the housekeepers will clean the seclusion room when instructed to by staff but it is the responsibility of the Nurse in Charge to ensure that this is completed and to check the seclusion room afterwards |

**To be returned to the Ward Sister / Charge Nurse**

| **Document any items reported/damaged and relevant reference numbers:** |
|---|
| |

# Appendix 18 Recording documentation in patient electronic records

### PROFORMA TO BE USED WHEN A PATIENT IS INITIALLY SECLUDED

**Events prior to seclusion:**

**Alternative risk management strategies implemented:**

**Details of any restraint and level of holds:**

**Rational for seclusion and time commenced:**

**Staff Present:**

**Clinical Duty Manager name, time contacted, and time attended:**

**Duty Doctor name, time contacted, and time attended:**

**Medication administered:**

**Physical concerns and monitoring completed (**Any physical obs taken - document if refused. Do levels of consciousness and resps if physical obs refused):

**Food and fluids offered / taken and left in seclusion**:

### PROFORMA TO BE USED FOR ALL SECLUSION REVIEWS

**Seclusion Review Time:**

**Type of Review:**

**Staff Present:** (in particular CDM and medical professional)

**Presentation of patient:** (including mental state, behaviour, risks and discussion contents with patient)

**Medication administered:** Compliance or noncompliance

**Food or fluids offered and given:** List what has been offered and left.

**Physical health assessment and monitoring (**any physical obs taken – document if declines; complete levels of consciousness and resps if declining physical obs**):**

**Decision:** (Rationale for seclusion continuing or Rationale for termination of seclusion - This will include evidence that mental state and risks have changed to warrant decision)

## PROFORMA TO BE USED FOR ALL OVER 48HRS SECLUSION / ENFORCED (SELF) ISOLATION / LONG-TERM SEGREGATION REVIEWS

**Name / NHS No. / Ward / Responsible Clinician:**

**Diagnosis:**

**Date isolation began:**

**Is this seclusion or LTS? If not, explain why**

**Definition of isolation in this case (**e.g., not leaving bedroom, only contact with staff**):**

**Rationale:**

**Is the person aware? What is their view?**

**Family / Advocate involvement:**

**Social contact plan:**

**Date / time of last MDT review:**

**Date for next review:**

**Is an IC(E)TR required?**

## Appendix 19 Long-Term Segregation Reviews Flowchart

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, an MDT review determines that a patient should not be allowed to mix freely with others on the ward on a long-term basis.

| | |
|---|---|
| **COMMENCEMENT** | • Organise MDT meeting to discuss with family / carer/ IMHA and commissioner and discuss steps needed to end LTS<br>• Create therapeutic activity plan<br>• Ensure patient has access to bed, bathroom and outside area<br>• Complete Care Plan<br>• Complete eIRF and ensure Safeguarding Tema are aware<br>• Complete Body Map |
| **DAILY** | • Daily review by approved clinician (Responsible Clinician or covering Consultant) or by ward doctor/ duty doctor, who must discuss the review with RC or covering Consultant<br>• There should be a review of the patient's presentation in the previous 24 hours including physical health and evidence of how the patient is working with the therapeutic plan |
| **WEEKLY** | • Review of current LTS plans within weekly MDT meeting, with attendance from a variety of disciplines<br>• There should be a review of the patient's presentation for the previous week<br>• There should be discussion about the ongoing plan to terminate LTS and how the patient is working to- wards it |
| **MONTHLY** | • Review of current LTS plans within weekly MDT meeting, with attendance from a senior manager, not involved in the patient's care.<br>• There should be a review of the patient's presentation for the previous month<br>• There should be discussion about the ongoing plan to terminate LTS and how the patient is working towards it<br>• Check Observations are complete for previous month<br>• Check daily reviews completed for previous month<br>• Check weekly reviews completed for previous month<br>• Complete Body Map<br>• Upload previous month's documents to EPR<br>• Ensure Care Plan & Risk Assessment updated<br>• Complete monthly eIRF to update Safeguarding & Incident Team of continued LTS<br>• Organise 3 monthly external review if applicable |
| **3 - MONTHL** | • Review with external hospital and commissioners<br>• Proforma to be completed and sent to external provider prior to review (review to be conducted with family/carer/IMHA representation) |

Continue with reviews until LTS is terminated

# Appendix 20 Proforma for Long-Term Segregation Commencement

**Staff present** (Must include various members of MDT, including RC, Commissioner and Family/Carer/IMHA):
**Views of each attendee**:
**Describe LTS area to be used (Evidence lounge area, bathroom, bedroom and outside area**:
**Therapeutic Activity Plan**:
**Plan to end LTS:**
**Date / Time agreed as commencement of LTS**:
**Actions (Tick as completed**):

| | |
|---|---|
| | Complete eIRF to inform Safeguarding Team |
| | Complete Body Map |
| | Complete Care Plan with information above |

**PROFORMA FOR OTHER REVEIWS**

**LONG TERM SEGREGATION DAILY REVIEW (**To include Responsible Clinician or covering Consultant or evidence that the review is discussed with them).
**Staff present**:
**Presentation of patient** (Include discussion on working towards plan to end LTS)
**Food / fluids**:
**Physical health assessment**:
**Decision**:
**Rationale**:

**LONG TERM SEGREGATION WEEKLY REVIEW** (including Senior Manager/Matron)

**Staff Present**:
**Presentation of patient** (Include discussion on working towards plan to end LTS)
**Food / fluids**:
**Physical health assessment**:
**Decision**:
**Rationale**:
**Actions (Tick as completed**):

| | |
|---|---|
| | Check Observations are complete for previous month |
| | Check daily reviews completed for previous month |
| | Check weekly reviews completed for previous month |
| | Complete Body Map |
| | Upload previous month's documents to EPR |
| | Ensure Care Plan & Risk Assessment updated |
| | Complete monthly eIRF to update Safeguarding & Incident Team of continued LTS |
| | Organise 3 monthly external review if applicable |

**TERMINATION OF LONG-TERM SEGREGATION**

**Actions**:

| | |
|---|---|
| | Check Observations are complete since last month's review |
| | Check daily reviews completed since last month's review |
| | Check weekly reviews completed for since last month's review |

| | |
|---|---|
| | Complete Body Map |
| | Upload previous month's documents to EPR |
| | Ensure Care Plan & Risk Assessment updated |
| | Ensure Post Incident Review completed (where possible) sign of eIRF |
| | Complete monthly eIRF to update Safeguarding |
| | Complete Care Plan with information above |

# Appendix 21 Recording Sheet for Commencement of Long-Term Segregation

**Recording Sheet for Commencement of Long-Term Segregation (LTS)**
***All parts must be completed**

| MHA Status | | eIRF No: | |
|---|---|---|---|

**Decision to nurse a patient in Long Term Segregation must be made by the MDT**

| | | | |
|---|---|---|---|
| **Nurse In Charge** [Print Full Name] | | | |
| **Duty Coordinator** [Print Full Name] | | | |
| **Responsible Clinician** [Print Full Name] | | | |
| **Family Member / Carer / IMHA** [Print Full Name] | | | |
| **Document views of Family Member / Carer / IMHA** | | | |
| **Other people involved in the decision** [Print names & Designation] | | | |
| **Date LTS Commenced:** | | **Time LTS Commenced** | |
| **Date LTS Terminated**: | | **Time LTS Terminated** | |
| **Total time in LTS** [Use 24-hour clock] | | **Location of LTS** | |
| **Reason for LTS:** | | **Does the patient have LD or Autism?** ☐ Yes ☐ No *[if YES, continue to the next questions]* | |
| **What alternative risk management strategies were implemented?** [e.g. de-escalation, low stimulus, medication]: | | **Did the episode exceed over 48 hours?** ☐ Yes ☐ No [if YES, continue] | |
| **Identified Risk Issues:** | | **Was the Discharge Hub notified?** ☐ Yes ☐ No [if NO, state reasons] | |

**Does the individual have access to** (tick as appropriate):

| | **YES** | **NO** | | **YES** | **NO** |
|---|---|---|---|---|---|
| **Bathroom facilities** | | | Bedroom | | |
| **Lounge** | | | Secure outdoor areas | | |
| **Range of Therapeutic Activities:** [Please Describe] | | | | | |

**Person responsible for ensuring completion of this form**:

NAME: SIGNATURE: DATE:

# Appendix 22 Review of Long-Term Segregation

**Review of Long-Term Segregation (LTS) Sheet for Commencement of Long-Term Segregation (LTS)**
**Review to be documented on EPR after completion and this serves as a signature for evidence**

| | |
|---|---|
| Date LTS commenced | |
| Time LTS commenced | |

| | | | |
|---|---|---|---|
| Type of Review (Please Circle) | **Daily Review** With MDT, including a doctor. | **Weekly MDT** with Responsible Clinician (RC) | **Date of Review:** **Time of Review:** |
| | **Monthly** with Senior Manager not involved in decision | **3 Month Review** Review with external hospital Discuss with IMHA (if involved) and Commissioner | |

| Name [Print Full name] | Designation | Signature |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Assessment (to include Mental State, Risks and Physical Health):**

Include record of any physical health monitoring

**Agreed Summary:**

**LTS to continue? Yes ☐ No ☐**

**Rationale for decision:**

**Form completed by:**

**Name:**_____ **Signature:**_____

**Designation:**_____

# Appendix 23 Termination of Long-Term Segregation

| | | | |
|---|---|---|---|
| **Has the LTS been terminated?** ☐ **Yes** | | | |
| Date LTS terminated | | Time LTS terminated | |
| Ward Sister/Charge Nurse (or deputy in absence) to sign as a record of completed paperwork before scanning to Electronic Patient Record | | | |
| Date | Print Name | | |
| | Signature | | |
| Quality Check by Matron after being uploaded to Electronic Patient Record | | | |
| Date | Print Name | | |
| | Signature | | |

**Ward Sister/Charge Nurse to check (Tick all that apply):**

| | |
|---|---|
| | Completeness of paperwork (each hour on observation charts completed) |
| | Reviews completed as per flow chart |
| | Reviews documented on EPR |
| | Check pre and post body maps completed |
| | Check post LTS patient review completed Check |
| | Risk Assessment & Care Plan completed |

**Matron Quality Check (Tick all that apply):**

| | |
|---|---|
| | Check Gaps in paperwork |
| | Are the reviews completed in full and as per flow chart? |
| | Are Reviews completed daily on EPR? |

# Appendix 24 Long-Term Segregation – External Review Template

Long Term Segregation – External Review template

| PART A – to be completed by treating team | |
|---|---|
| Patient Initials | |
| Responsible Clinician | |
| Ward | |
| Date LTS commenced | |
| Location of segregation | |
| Rationale for Use of segregation | |
| LTS environment: include<br>Is there access to a bedroom, lounge, bathroom and a secure outdoor area?<br>Has there been personalisation of the environment? | |
| Summary of clinical profile | |
| Summary of current risk profile – last 3 months | |
| Risk management plan | |
| Current multidisciplinary treatment plan | |
| Stakeholder engagement – include summary of involvement of carers, advocacy and case manager | |
| What are the criteria to end LTS? Describe any current integration strategy and progress | |
| Actual time out of segregation and % of time out (estimate) | |
| Patient's View | |
| **PART B- to be completed by external panel** | |
| **External Reviewer comments:**<br>**Is LTS still justified and proportionate?**<br>**Areas of good practice?**<br>**Areas of concern? Is a face to face review required?**<br>**Any specific recommendations?** | |

# Appendix 25 Guidance for Doctors in Seclusion

**Guidance for Doctors on Seclusion**

1. As per the Trust's Policy and the Mental Health Act Code of Practice guidelines patient's consultant (responsible clinician) or duty doctor will either be directly involved or informed of seclusion as soon as it is practicable.

2. Please note that all seclusion reviews, (Medical, Internal MDT and Independent MDT reviews) should take place face to face and not over the telephone. **Following the review there should be a clear entry documented on the SystmOne records of the patient by a medic. Consultants must document their findings on system1 of seclusion reviews they have completed**

**3. Medical Reviews**

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**. This review can be done by the Responsible clinician or resident doctor.

- Continuing medical reviews **every four hours (this requirement includes evenings and weekends etc.)** until the first internal MDT review. Medical reviews can be done by any doctor. After the first internal MDT review the R.C can reduce the medical reviews to every 8 hours if this is appropriate.

- **Medical reviews must happen on time. For resident doctors only a medically unwell patient should take priority over seclusion reviews. There must be a clear entry on the notes for each medical review.**

- Medical reviews can take place at the same time as an internal or independent review of seclusion.

**4. Internal MDT Reviews**

The First Internal MDT Review must include the Responsible clinician or covering Responsible clinician, (or at the Bradgate or Willows the on-call covering GA consultant, for Beacon ward out of hours this would be the on-call CAMHS consultant, for the Agnes Unit this would be the on-call LD consultant).

The first (internal) multi-disciplinary team review should take place as soon as is practicable, (we would not expect this to exceed 12 hours). These should then continue every 24 hours with the Responsible clinician, nursing staff, resident doctors, and other members of the MDT.

Following first (internal) multi-disciplinary team review, **medical reviews can be reduced to 8 hourly if this is thought appropriate.** This should be documented in the progress notes and in the seclusion care plan**. If this is not documented the medical reviews should continue every 4 hours**

Internal MDT reviews always require a consultant present. The consultant should attempt to speak to the patient. There must be clear documentation of the internal MDT review of seclusion from a medic, including the rationale for ongoing seclusion. Resident doctors are not necessarily required at internal MDT reviews, (for example at weekends if they are busy at the Bradgate unit and cannot attend).

**5. Independent MDT Review**

**If a patient has been in seclusion continuously for 8 hours then an independent review of seclusion should take place. It has been agreed that the independent reviews of seclusion**

**will only take place between the hours of 9am and 9pm, 7 days a week.** The independent MDT should include a consultant who is not involved in the patients care, or decision to commence seclusion. That consultant should identify when the next Independent MDT should take place – we would suggest that once a week is the minimum level of independent MDT reviews.

During 9am -9pm the Responsible clinician will try to identify a consultant for the independent review. If the on call doctor is needed at the Bradgate the GA consultant who does not cover the Bradgate will be the independent consultant. Out of hours the GA consultant who does not cover the Willows will be the independent consultant. For Ward 3 we suggest the LD on call consultant becomes the independent consultant, and for the Agnes Unit the CAMHS on call consultant becomes the independent consultant.

Independent MDT reviews always require a consultant present. That consultant must speak to the patient and must document their findings in System 1, including the timing of the next independent review. Independent reviews must be documented by the consultant.

6. **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
    - An assessment of the need for continuing seclusion and whether it is possible for it to seclusion measures to be applied more flexibly or in a less restrictive manner

**7. What do I do if the patient is asleep?**

Each individual situation must be assessed separately. For example, if a manic patient has just gone to sleep it may not be appropriate to wake the patient

However, the review should still happen. For medical reviews/internal or independent reviews the doctors should still document the patients physical state, (e.g., Respiratory rate), the rationale for not waking the patient, and the rationale for seclusion to continue. For internal or independent MDT reviews these will then need to happen in a timely fashion when the patient is awake

# Appendix 26 Governance

## Version control and summary of changes

| Version Number | Date | Comments (description change and amendments) |
|---|---|---|
| [1] | May 2015 | Extensively revised in response to the publication of the Mental Health Act Code of Practice 2015. |
| [2] | June 2015 | Revised following comments made by members of the Seclusion Group at its meeting of 4th of June 2015.<br>Amendments made to reflect the NICE guidance 'Violence and aggression: short-term management in mental health, health and community settings'<br>(2015) |
| [3] | July 2015 | Revised following comments made about version 2.<br>Title changed to Seclusion and Restrictive Practices Policy<br>Procedure for the use of the extra care facility<br>within the CMHS inpatient unit added |
| [4] | August 2015 | Revised following comments made about version 3.<br>Revised following comments made by members of the Seclusion Group at its meeting of 31st of July 2015.<br>Addition of training pack and competence assessment tools |
| [5] | September 2015 | Revised following comments made by members of the Seclusion Group at its meeting of 8th of September 2015.<br>Addition of competence assessment tools with criteria to meet<br>Addition of Seclusion Review Record Sheet |
| [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.<br>Inclusion of text relevant to children and young people under 18.<br>Addition to review standards with particular<br>reference to isolated or stand-alone units. |
| [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. |
| [8 & 9] | 2018 | Updated to reflect least restrictive practice and Positive and safe work. |
| [10 & 11] | May 2019 | Revised policy with new documentation for seclusion following improvement cycle.<br>Revised layout of forms. |
| [12] | September 2019 | Revised forms following improvement cycle. Amended nursing reviews for seclusion and Long Term Segregation and reflected in policy document. |
| [13] | June 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 |
| [14] | September 2020 | Slight amendments to record forms and change to role and responsibility of the Clinical Duty Manager. |
| [15] | August 2021 | |
| [16] | April 2024 | Inclusion of amended forms, updates to governance processes. |
| [17.1] | January 2025 | Amendments made to Training Needs Analysis, Due Regard, Long-term segregation audit requirements, medic reviews timescale requirements, seclusion in a non-ward area prior to admission added, respiratory rates monitoring requirement, and Capacity assessment requirement as part of seclusion initiation documents |
| [17.2] | April 2025 | Quick look summary added |
| [17.3] | October 2025 | |

## Responsibilities

| Responsibility | Title |
|---|---|
| Executive Lead | *Executive Director of Nursing, AHP's and Quality* |
| Policy Authors | *Head of Nursing, AHPs & Quality, Directorate of Mental Health (DMH) Patient Safety Incidents Response Lead, Directorate of Mental Health (DMH)* |
| Advisors | *LPT Corporate Patient Safety Lead* |
| Policy Expert Group | Least Restrictive Practice Group |

## Assurance

| Governance Level | Name |
|---|---|
| Level 1 Assurance Oversight | Quality & Safety Committee |
| Level 2 Delivery Group for policy approval and compliance monitoring | Safety Forum |

## Compliance Measures (Standards / Performance Indicators

| TARGET/STANDARDS | KEY PERFORMANCE INDICATOR |
|---|---|
| Incidents are reviewed for learning and reported to Least Restrictive Practice Group that reports into Safety Forum | |
| Matron's Quality Checks to ensure seclusion records are maintained, reported in annual audit to Least Restrictive Practice Group | |
| Review of seclusion meetings with nurse manager received at Least Restrictive Practice Group monthly until the policy is embedded. | Consistent completion of the post-seclusion review and Ward Sister / Charge Nurses quality check. |

| | |
|---|---|
| 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. |

## Training Requirements

| Training |
|---|
| *What relevant training is available for staff to support the understanding and implementation of this policy.* |

## Appendix 27 Policy Stakeholder and Consultation

Key individuals involved in developing the document:

| Name | Designation |
|---|---|
| Accountable Director | Linda Chibuzor - Executive Director of Nursing, AHP's and Quality |
| Author(s) | Saskya Falope – DMH Head of Nursing, AHPs & Quality<br>Rachael Shaw – MHSOP Matron<br>Olajumoke Fatuga – DMH Patient Safety Incidents Response Lead |
| Implementation Lead | Saskya Falope; DMH Head of Nursing, AHPs & Quality |
| Core policy reviewer group | Least Restrictive Practice Group |

Circulated to the following individuals for comments and consultation of this version: