SECLUSION AND LONG - TERM SEGREGATION (LTS) POLICY
MAY 2020

This policy supersedes all previous policies related to Seclusion and LTS
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**Membership of the policy development/review team**

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**Consultation**

In-patient Ward Managers  Matrons and, Consultants, Positive and Proactive steering group members

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1. **INTRODUCTION**

1.1 Seclusion and LTS are considered a substantial invasion of an individual’s civil liberty and other less restrictive interventions should be attempted wherever feasible including: negotiation; de-escalation; diversion; as required medication; etc. Any use of restrictive interventions must be compliant with the Human Rights Act 1998 (HRA) and should only be used where it is medically necessary and based on the level of risk, if it is not medically necessary it may breach a patient’s rights under Article 3, which prohibits inhuman or degrading treatment. Unless a patient is detained under the MHA or is subject to a deprivation of liberty authorisation or Court of Protection order under the MCA, staff must be careful to ensure that the use or restrictive interventions does not amount to a deprivation of liberty and breach Article 5 of the HRA (the right to liberty). Clear evidence of all interventions should be recorded in the clinical records and the seclusion/LTS documentation.

1.2 The safety and welfare of staff, service users, families, carers, contractors and visitors who are in contact with Trust services is of paramount importance (HASAWA, 1974). This policy promotes safe practice, particularly focusing on the use of seclusion and/or LTS, as a means of reducing the risks associated with challenging behaviour in the form of violence, aggression and harassment. Seclusion and LTS are forms of restrictive intervention and should only ever be used as a last resort and the least restrictive option to safely manage risk.

**Policy Statement**

1.3 The Trust has an obligation to protect service users, staff and visitors who enter their premises and is committed to ensuring that the regulations/guidance informing this policy are fully implemented. The Trust also expects staff members to uphold the Trust Values while carrying out their responsibilities to ensure compliance with the policy.

1.4 The Mental Health Act 1983 requires that anybody working within the framework of mental health ‘shall have due regard for the Code (of Practice)’ (s.118 (2D)). This policy makes direct reference to the Mental Health Act 1983 (amended 2007): Code of Practice (2015) (MHA CoP) and sets out the context and framework within which staff will practice, It is the responsibility of all members of the Patient Care Team and their managers to ensure that seclusion and long-term segregation is used as described within this policy, departure from it and from the MHA CoP is only authorised under exceptional, justifiable circumstances, and only where there are cogent reasons for doing so.

1.5 Unless otherwise stated, all references to the ‘Code’ or ‘Code of Practice’ given throughout this policy refer to the 2015 edition of the Mental Health Act 1983 Code of Practice, with all references to ‘Chapter 26’ relating to the specific chapter and section of the Code.
2. **SCOPE OF THE POLICY**

2.1 This Policy is for all staff members that work across the inpatient sites in St. Pancras Hospital and Highgate Mental Health Centre. All staff that work on these sites should have a full understanding of the policy.

3. **AIMS AND OBJECTIVES**

- Differentiate between seclusion, long-term segregation and psychological behaviour therapy interventions (such as “time out”).
- To provide best practice guidance on the use of seclusion and LTS
- To safeguard the human rights of service users who are being cared for in inpatient services
- To support the Trust commitment to promoting and supporting a safe therapeutic environment and reducing the use of restrictive interventions [Chapter 26.6].
- To ensure restrictive practices remain proportionate, least restrictive, last for no longer than is necessary, and take account of patient preference wherever possible [NICE NG10, 2015]
- Provide positive and caring environments that promote the safety and high quality care of patients
- Effectively manage situations that potentially or actually place service users, in a seclusion or extra care environment
- Support the trusts PMVA and Business continuity polices
- Provide prompt, safe and appropriate care to service users who demonstrate severely disturbed behaviour
- To meet and uphold the guiding principles of the Mental Health Act Code of Practice as highlighted in Chapter 26.110.
  - ensure the physical and emotional safety and wellbeing of the patient
  - ensure that the patient receives the care and support rendered necessary by their seclusion both during 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
  - set requirements for the recording, monitoring and reviewing of the use of seclusion and any follow-up action
- Meet training needs of all staff
- Monitor compliance with all of the above
4. **DUTIES AND RESPONSIBILITIES**

4.1 **The Chief Executive** has ultimate responsibility for ensuring that mechanisms are in place for the overall implementation, monitoring and revision of policy.

4.2 **The Executive Director of Nursing and Quality** has Trust board accountability for Nursing & AHP practice, clinical quality, CQC compliance and reducing restrictive practice.

4.3 **Divisional Directors** are responsible for implementation of the policy within their own spheres of management and must ensure that:

- All new and existing staff have access to and are informed of the policy
- Ensure that local written procedures support and comply with the policy
- Ensure the policy is reviewed regularly
- Staff training needs are identified and met to enable implementation of the Policy

4.4 **The Head of Governance and Quality Assurance, via the Clinical and Corporate Policy Manager**, is responsible for ensuring:

- In conjunction with the Policy Lead identifies resource implications to facilitate implementation and compliance.
- Training and monitoring systems are in place.
- Regular review of the policy takes place.

4.5 **Ward/Team Managers** are aware of their responsibilities for procedures set out in Section 6. These may be delegated under a locally agreed and signed policy. Overall responsibility, however, remains with the manager of the ward or clinical department.

4.6 **Emergency Response Team (ERT)** is a designated group of healthcare clinicians who can be assembled quickly to support teams or services in response to any situation which requires additional resources to safely manage an emergency to the trusts inpatient services, in this case seclusion.

**The Duty Doctor** is the senior medical clinician on site out of hours

**The Silver Command** is the senior on-call Manager for the Trust

**The Gold Command** is the senior on-call director for the Trust

4.7 **The Positive and Proactive Care Group** are responsible for the following areas and report any concerns to the Quality Governance Committee:

- Monitoring and recommending changes to practice, and ensuring adherence to national guidelines and standards relating to violence management
- Recommending and planning related training
- Determining the choice of equipment required to manage violence or aggression
• Preparing policies relating to positive management and prevention of violence and aggression
• Ensuring that current guidelines on prevention and management of violence and aggression are reflected in the Trust’s relevant policies.
• Reviewing incident data in relation to violence in which patients, staff or visitors safety may have been at risk
• Review and develop action plans following incident reviews
• Review the use of seclusion and the quality of care that is provided to service users that are placed in seclusion

4.8 All Trust staff are responsible for ensuring that they:
• Are familiar with the content of the relevant policy and follow its requirements
• Work within, and do not exceed their own sphere of competence

5. DEFINITIONS

Seclusion

5.1 The Mental Health Act Code of Practice [26.103-104] has defined Seclusion as: “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 immediate necessity for the purpose of containment of severe behavioural disturbance which is likely to cause harm to others.”

“If a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded and the use of any local or alternative terms (such as ‘therapeutic isolation’ or segregation) or the conditions of the immediate environment do not change the fact that the patient has been secluded.”

Time-Out

5.2 A period of time where a patient is requested to spend a small period of time away from the general population of the ward, this should be time limited to less than 10 minutes and at no point should staff prevent the patient from leaving the time-out area. [MHA CoP 26.58]

Long -Term Segregation (LTS)

5.3 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. It is determined that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. [MHA CoP 26.170]
6. **POLICY CONTENT**

**Principles of Seclusion**

6.1 The nature and manner in which seclusion is used, the reason for its use, and the consequences or outcome should be recorded in an open and transparent manner [MHA CoP 26.64].

- Seclusion should be used as a last resort and for the shortest length of time possible
- Seclusion should not be used as either a punishment or a threat, or because of a shortage of staff, nor should it form part of a treatment programme
- Seclusion should never be used solely as a means of managing self-harming behavior [MHA CoP 26.107-108]

6.2 Seclusion should only be used in relation to patients detained under the Act. “If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately” [MHA CoP 26.106]. Staff should where necessary consider the use of Section 5(2) or 5(4) of the Mental Health Act.

6.3 In order to ensure that seclusion measures have a minimal impact upon a patient’s autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient’s circumstances. In cases of prolonged seclusion such flexibility, following risk assessment, may include allowing patients to receive visits, provide access to secure outside areas, or to have meals in the general areas of the ward [MHA CoP 26.111].

**Principles of ‘Time-Out’**

6.4 It is worth noting that ‘time-out’ is referred to in the MHA CoP [26.58] as a “specific behavioural change strategy” in children and young people. “Time-out might include: preventing a child or young person from being involved in activities which reinforce a behaviour of concern until the behaviour stops; asking them to leave an activity and return when they feel ready to be involved and stop the behaviour; or accompanying the child or young person to another setting and preventing them from engaging in the activity they were participating in for a set period of time. If time-out processes have the features of seclusion, this should be treated as seclusion and comply with the requirements of the Code.”

6.5 The use of the term ‘time-out’ should be avoided in adult acute settings, in the event that its principles are used to reduce tension, prevent escalation or conflict (for example encouraging a patient to spend time in their bedroom or a quite area away from other people), this should be documented as a de-escalation strategy.

6.6 Time-out or any strategy that follows its principle must never be used as a punishment or as a punitive measure to control behavior. The patient must be agreeable without any coercion to being separated from the rest of the ward for a period of time, and the therapeutic benefits of this discussed with the patient. Time out must be for a brief and limited period of time that is followed up with engagement between staff and the service user.
The Environment

6.7 Seclusion should only take place in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serve no other function on the ward [MHA CoP 26.105]. However, in exceptional circumstances and for cogent clinical reasons it may be considered more therapeutic and less restrictive to manage a patient requiring isolating from peers and/or staff in their own bedroom.

6.8 The Trust is committed to working towards ensuring that designated seclusion rooms meet the criteria identified within the Code [26.109] in that they will

- Allow for communication with the patient when they are in the room and the door is locked
- Have limited furnishings which should include a bed, pillow, mattress, and blanket or covering
- Not have any apparent safety hazards
- Have robust and reinforced windows that provide natural light (and where possible the window should be positioned to enable a view outside)
- Should have externally controllable lighting, including a main light and subdued lighting for night time
- Have robust doors which open outward
- Have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
- Not have any blind spots
- Have a clock visible to the patient from within the room
- Have access to toilet and washing facilities

6.9 Wherever possible a patient should only be secluded in a designated seclusion environment however, In the event that a patient is secluded in an environment that is not a designated seclusion suite (e.g. a bedroom), every effort must be made to immediately move them to an appropriate environment, or consider terminating the seclusion.

6.10 If seclusion occurs outside of the seclusion environment, the Nurse in Charge (NIC) must immediately inform the matron for the service during the hours of 09:00-17:00 and the Bed Manager outside of these hours. The Duty Dr out of hours must also be made aware and informed of the review schedule. The Bed Manager must inform the silver on call out of hours if seclusion outside of the designated seclusion environment has occurred.
When to use seclusion

6.11 Seclusion should only be considered when the risk the patient poses to others cannot be safely contained by any other means, and other individuals are at direct risk from harm.

6.12 Seclusion should never be used when a patient’s main presenting risk is self-harm or suicidal intent. “Where the patient poses a risk of self-harm as well as harm to others, seclusion should 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 arising from their own self-harm and that any such risk can be properly managed” [MHA CoP, 26.107].

6.13 Seclusion must only be considered as a last resort and all other approaches to manage the acutely disturbed behaviour must have been exhausted including:

- De-escalation
- Pharmacological interventions including the use of PRN medication and Rapid Tranquilisation
- Enhanced observations including 2:1 arm’s length observations, engagement, distraction and activity
- The decision to seclude the patient must be based on the risk assessment of the patient, taking into account all environmental and clinical indicators. These must be listed in the seclusion document at the time of seclusion commencing

Decision to seclude a patient

6.14 The decision to implement seclusion can be made by either the nurse in charge of the ward, a psychiatrist, or an approved clinician. The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion [MHA CoP 26.112-114]

Commencement of Seclusion

6.15 The nurse in charge should decide what the patient can take into the seclusion area/room (based on individual risk assessment); noting that the patient should never be deprived of clothing [MHA CoP 26.113]. Any property removed must be documented, kept in a safe place and the patient informed of its location. When a patient is placed in seclusion, the start time and date of the seclusion should be recorded [MHA CoP, 26.115].

6.16 If the decision to seclude was not made by the patient’s Responsible Clinician (RC) then the patient’s RC or duty doctor should be informed as soon as practicable [MHA CoP, 26.112] and should attend for a medical review within one hour or without delay if the patient is newly admitted, or not well known, or there is a significant change in their usual presentation. If the seclusion was authorised by a psychiatrist the first medical review will be that undertaken immediately prior to the commencement of seclusion. Therefore there will be no need for a further review within one hour [MHA CoP, 26.116]
6.17 Any occasion where a doctor fails to arrive for an initial assessment/review of seclusion within an hour will result in the nurse in charge completing a DATIX incident form that will be reviewed by senior managers. (This should be recorded as a Service provision failure).

6.18 It is considered good practice that there should normally be a minimum of three staff present before the seclusion room door is opened to a secluded patient.

6.19 If safe to do so (taking into account the clinical presentation of the patient and the risks identified) the doctor attending for the first review following the commencement of seclusion should physically examine the patient in the seclusion room.

6.20 A clinical assessment of risk must be undertaken for all patients in seclusion and if the decision following the initial medical review is that seclusion should continue, then a seclusion care plan should be developed [MHA CoP, 26.129] and placed in the patient’s healthcare record. As a minimum the care plan must include:

- Assessment and management of risks presented
- Steps to be taken towards the safe termination of seclusion as soon as is practicable
- The patient’s communication needs
- Clothing/bedding needs
- Any reviews of medication required
- Details of access to personal hygiene/toileting facilities
- Details of access to or restrictions to eating utensils and reading materials
- Assessment of fluid and nutritional needs
- The monitoring of a patient’s physical condition when parenteral medication (either depot or emergency medication or rapid tranquillisation) has been, or is due to be administered
- Reference to a positive behavioural support plan or advanced statement
- The patient’s views regarding his/her being secluded
- Information about how relatives or carers are to be kept informed (dependent upon previously agreed positive behavioural plans or advanced statements)

6.21 Attempts should be made to include the patient in the development of the seclusion care plan at the earliest opportunity [MHA CoP 26.148]. These attempts should be documented in the patient’s healthcare record. If the patient is unwilling or not able to contribute to the development of the plan then the plan should be explained to them.

6.22 The patient should be provided with a copy of the care plan unless clinically contra-indicated. Such decisions to withhold care plans should be documented in the patient healthcare record.

6.23 The nurse in charge of the ward is responsible for ensuring the seclusion room is of an acceptable standard with respects to cleanliness, ventilation, lighting, heating and safety before a patient is secluded within it.
The nurse in charge of the ward is responsible for ensuring that any potential hazards or risks identified within the environment are brought to the attention of the Responsible Clinician or duty doctor and senior nurse on duty immediately, so that risk management strategies can be identified to ensure the continued safety of the patient during seclusion.

The nurse in charge of the ward is responsible for ensuring that all documentation and observation forms/records have been completed correctly.

Family members should be notified of the use of seclusion if previously agreed in either a positive behavioural support plan or advanced statement.

Each division will ensure that all records pertaining to seclusion will be kept as part of an identified seclusion reporting system.

The nurse in charge of the ward, or ward manager as appropriate, must ensure there is provision for staff/patient support and de-brief after an incident resulting in the use of seclusion in the form of individual/group discussion and/or clinical supervision.

Deprivation of daytime clothing

Patients should never be deprived of appropriate daytime clothing with the intention of restricting their freedom of movement. They should not be deprived of other aids necessary for their daily living. The MHA CoP makes clear that patients should have access to their own clothes; however, where this is not possible, clear clinical justification must be provided within the patient’s notes supporting the reasons for the removal of clothing and the alternatives which have been provided.

Staff must ensure that the patient is searched to ensure they do not retain any articles that may cause harm to self or others e.g. matches, nail files, pyjama cords, plastic bags, shoes, belts, neckties etc.

Use of Seclusion tear-proof clothing

The Trust recognises that at times some patients may present a serious risk to themselves if they have access to their own clothing whilst in seclusion. Patients may be at risk of fashioning ligatures from their clothing. Consideration may be given to the use of tear proof clothing, for the least amount of time necessary, where a risk assessment has been completed and has shown that the use of the patient’s own clothes presents a significant risk. An MDT should undertake an individual risk assessment before this decision is taken. The decision to ask the patient to wear special tear-proof clothing should be authorised by the patient’s responsible clinician.
6.32 The use of seclusion tear-proof clothing will have an impact on the patient’s dignity and, therefore, their use will be implemented subject to the following criteria being met and followed:

- The patient will be assessed as presenting a high risk of suicide/accidental harm by ligation. The patient is making active attempts to fashion ligatures from their clothing. Tear-proof clothing should never be a first-line response to such risks. Verbal de-escalation must be evidenced and documentation supports this.
- Its use should be proportionate to the risk posed by the patient and used only where absolutely necessary.
- It must never be used as a substitute for enhanced levels of support and observation.
- The patient should be told what they need to do so that they can wear their usual preferred clothing and this should be detailed in their care plan.
- Nurse in Charge or other suitably qualified practitioner will discuss the rationale for consideration of use of tear proof clothing with the on call manager and RC (or their nominated deputy). The outcome of this discussion will be documented in the seclusion records and patient’s clinical records.
- Tear-proof clothing should fit the person so as to preserve their dignity and should, where possible, meet any specific cultural or religious requirements.
- Where tear proof clothing is removed from the storage box in the enhanced care area, the recording sheet in the box should be completed and signed by the Nurse in Charge or other suitably qualified practitioner.
- The use of tear proof clothing will be reviewed during each seclusion review and the outcome clearly documented in the seclusion records and patient’s clinical records.
- On termination of the seclusion episode the patient’s clothing should be returned to them.

Arrangements for the care of Seclusion tear-proof clothing

6.33 The following considerations will be applied where tear proof clothing is being worn:

- If tear proof seclusion clothing is utilised for a period exceeding 12 hours then a change should be offered; this will be evidenced within the seclusion record and patient’s clinical records.
- Following use all tear proof clothing should be laundered at 60 degrees.
- Tear proof clothing should always be returned to the storage box in enhanced care area and signed back in.
• Prior to returning the garments to the storage box in the enhanced care area a full check of the item should be made and, if any damage, the garment is to be returned to the Nurse in Charge or other suitably qualified practitioner (out of hours) for replacement.

Engagement, Observation and Record Keeping

6.34 On commencing seclusion, the patient will be placed on continuous eyesight observation (1:1); a collaborative decision should then be made between the Doctor and the Nurse in charge of the ward as to the appropriate level of observations required. For patients who have received sedation, a skilled professional will need to be outside the door at all times (MHA CoP, 26.122).

6.35 Throughout the patient’s period of seclusion, a suitably skilled professional should as a minimum be readily available within sight and sound of the seclusion area at all times and should have the means to summon urgent assistance from other staff should the need arise at any point. Consideration should be given to whether a male or female person should carry out on-going observations; this may be informed by patients past history (i.e. trauma), advanced statement or religion.

6.36 The reason for carrying out these observations is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end.

6.37 A record of the patient’s behaviour should be made at least every 15 minutes, it should include, where applicable: 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. Where the patient appears asleep, the observing staff “should be alert to and assess the level of consciousness and respirations of the patient as appropriate”. (MHA CoP, 26.123-125)

6.38 The seclusion record should also provide the following details:

- **Who authorised the seclusion**
- **The reason(s) for seclusion**
- **What the patient took into the seclusion room**
- **If and when a family member, carer and/or advocate was informed of the use of seclusion**
- **15 minute recordings by the person undertaking continuous direct observation**
- **Details of who undertook scheduled nursing reviews, their assessment, and a record of the patient’s condition and recommendations**
- **Details of who undertook scheduled medical reviews, their assessment and a record of the patient’s condition and recommendations**
Visiting a Secluded Patient

6.39 The patient must be able to communicate and see a member of staff at all times during the period of seclusion. Wherever possible relatives and carers must be able to visit a patient who is being nursed in seclusion, if it is decided by the MDT to not allow visitation this must be documented in the seclusion care plan. Reasons may include:

- The secluded patient has specifically requested to not have visitors
- The visit is likely to increase the secluded patient’s level of agitation and prolong the seclusion period

6.40 Unless it is safe to do so and patient has given consent, relative or carer should not enter the seclusion room whilst it is in use. Wherever possible phone calls with relatives and carers should be facilitated via the audio equipment in the Seclusion Environment.

Seclusion Reviews and Psychiatric Observations

6.41 All patients in seclusion must be continuously reviewed in line with the MHA CoP 2015, these include the multi-disciplinary team (MDT), nursing, medical and independent MDT reviews. All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient’s mental and physical state (MHA CoP, 26.126). The names and designations of all staff entering the seclusion room should be recorded in the seclusion record.

Nursing Reviews

6.42 Nursing reviews should take place at least every two hours by two registered nurses, one of whom was not directly involved in the decision to seclude [MHA CoP 26.134]. The outcome of these nursing reviews should be recorded in the patient’s healthcare record.

6.43 Any concerns regarding the patient’s physical or mental condition should be brought to the immediate attention of the patient’s Responsible Clinician or duty doctor [MHA CoP 26.135]. For nursing reviews during the night or when a patient is asleep (see section on night time review below).
6.44 Unless seclusion was authorised by a psychiatrist, a seclusion review will be undertaken by a doctor within the first hour of seclusion commencing, or without delay if the patient is newly admitted, not well known, or if there is a significant change in their usual presentation [MHA CoP 26.116]. If after the first medical review the decision is that seclusion should continue then a seclusion care plan should be developed in collaboration with nursing staff.

6.45 The Trust has determined that all medical doctors, irrespective of grade, or level of registration will be considered competent to undertake medical reviews on the provision that they meet the following criteria

- Have read this policy
- Have access to senior medical (consultant) advice at all times
- Have access to senior nursing advice at all times

6.46 Medical reviews will take place every four hours from the commencement of seclusion until the first Internal Multi-disciplinary Team review takes place. Following this first Internal Multi-Disciplinary Team review further medical reviews should continue at least twice in every 24hr period [MHA CoP, 26. 131-132]. At least one of these twice daily reviews should be by the patient’s Responsible Clinician, or an identified deputy covering for them out-of-hours (e.g. a duty doctor) [MHA CoP, 26.127].

6.47 A Medical Review involving a Consultant Psychiatrist wherever possible should be completed face to face by a Consultant Psychiatrist, however if this is not possible due to the review falling outside of normal working hours (Monday – Friday 09:00-17:00), then the consultant on-call must have phone contact with the delegated doctor that has completed the review in their place.

6.48 Outcome of the medical reviews should be recorded in the patient’s healthcare record.

Medical reviews should be carried out in person (for medical reviews during the night see section on night time review below) and provide the opportunity to evaluate and amend the seclusion care plan [MHA CoP 26.133]. Such reviews should

- Review the patient’s physical and psychiatric health and assess any adverse effects of medication
- Review the level of observations required and reassess prescribed medication
- Assess the level of risk to others and risk of deliberate or accidental self-harm
- Assess the need for the continuation of seclusion
- Assess potential measures to allow greater flexibility in seclusion to reduce the restrictive nature of the seclusion episode
MDT Reviews

6.49 Internal MDT
The first internal MDT seclusion review should be held as soon as is practicable and before the
Independent MDT Review. This should include Responsible Clinician, the senior nurse on the
ward, and staff from other disciplines who would normally be involved in the patient’s
care/reviews.

At weekends or public holidays, membership of this review team may be limited to medical and
nursing staff, in which case the Gold on-call should be involved over the phone. Further MDT
reviews should take place once in every 24-hour period of continuous seclusion. Where seclusion
continues, these reviews should evaluate and make amendments, as appropriate, to the
seclusion care plan (MHA CoP 26.147).

6.50 Independent MDT review
The independent MDT review will include a doctor, a nurse, where possible a senior clinician who
is neither a doctor nor a nurse, an IMHA if available and other professionals who were not
involved in the incident that led to the seclusion. It is good practice to consult those involved in
the original decision to better inform this review [MHA CoP, 26.142].

6.51 If a patient has been secluded continuously for longer than 8hrs consecutively or 12hrs
intermittently during a 48hr period then an independent MDT review should be undertaken [MHA
CoP, 26.141]

Night Time Reviews

6.52 Chapter 26.136 of the Code of Practice allows for alternative review arrangements during the
night. The Trust recognises the value in allowing patients periods of uninterrupted sleep and the
potentially disturbing nature of reviews during the night

6.53 Where a patient appears to be sleeping, a clinical judgement needs to be made on whether it is
appropriate to wake them for a medical review. In such instances the doctor’s attendance for the
medical review may be replaced by a telephone review with the nurse in charge of the ward.

6.54 The decision to hold a telephone review needs to be agreed jointly by the doctor and nurse in
charge of the ward and may only be agreed on an individual basis subject to the patient being
asleep at the time the review is due. In the absence of a positive decision to have a telephone
review, the default position will be that the doctor attends for the medical review.

6.55 When there are specific concerns around the physical health of the patient, the default position of
the doctor attending for medical reviews should continue during the night. If the patient is asleep
these reviews should be carried out in such a way that the doctor can satisfy themselves that the
patient is safe and that any concerns for physical health and wellbeing can be addressed safely.

6.56 When the patient is asleep, the two hour nursing reviews should be carried out in such a way that
the registered nurse can satisfy themselves that the patient is safe and there are signs of life.
Physical Health Observations during Seclusion

6.57 Every patient that is in seclusion should have a full set of physical health observations attempted at every review; the full schedule of the Physical Health Observations can be seen in Table 1.

6.58 All observations must be documented in the NEWS Chart and in the seclusion review document on CareNotes.

6.59 If there are concerns about the patient’s physical health the duty doctor should be requested to assess the patient if possible and/or seclusion should be immediately terminated and the patient transferred to A&E.

6.60 The NEWS action protocol must be followed at all times. The NEWS clinical indication system shown below gives a basic guide on what is clinically indicated for the NEWS of the patient. Please refer to the trust’s physical health and wellbeing policy for more information on NEWS:
## 6.61 Seclusion Review Table

Reviews must be in line with the schedule outlined in Table 1 below.

<table>
<thead>
<tr>
<th>Time in Seclusion</th>
<th>Review required</th>
<th>Physical Health observations</th>
<th>Staff required</th>
<th>Additional (Alternative?) Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continual observations On transfer to the seclusion area??</td>
<td>Constant.</td>
<td>Every 15 minutes: Respiratory rate, conscious level</td>
<td>Permanent member of staff assessed as competent in Seclusion Observations</td>
<td>None</td>
</tr>
<tr>
<td>1 Hour</td>
<td>Medical review if a doctor was not present at the time seclusion initiated.</td>
<td>Full NEWS to be offered if safe to conduct, provide food and drinks</td>
<td>Nurse in Charge, Ward Manager, Responsible Clinician, supervising member of staff, ERT</td>
<td>Bed Manager (If ward manager not available), Duty Doctor (If Responsible Clinician not available)</td>
</tr>
<tr>
<td>2 Hours</td>
<td>Nursing review</td>
<td>Full NEWS to be offered, provide food and drinks</td>
<td>Nurse in charge, senior nurse, supervising member of staff, ERT</td>
<td>Bed Manager (If Senior Nurse not available)</td>
</tr>
<tr>
<td>4 Hours</td>
<td>Medical review</td>
<td>Full NEWS to be offered, hydration levels, provide food and drinks</td>
<td>Nurse in Charge, Senior Nurse, Responsible Clinician or Duty Doctor, supervising member of staff, ERT</td>
<td>Bed Manager (If Senior Nurse not available)</td>
</tr>
</tbody>
</table>

Following the 4 hour review Seclusion reviews should occur every 2 hours following the same process of the two 2 hour and 4 hour (Nursing and Medical), this to continue until 24 hours when a senior review occurs. Once the 24 hours has passed the process re-starts from the 2 hour point

Please see below for details

<table>
<thead>
<tr>
<th>24 Hours</th>
<th>Senior</th>
<th>Full NEWS to</th>
<th>Responsible</th>
<th>Covering</th>
</tr>
</thead>
</table>
**Seclusion and Long-Term Segregation (LTS), Updated March 2020/SF, AI**

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Reviewer</th>
<th>Frequency</th>
<th>Activities</th>
<th>Consultant (If Responsible Clinician not available)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(Monday – Friday 09:00-17:00)</strong></td>
<td>MDT Review</td>
<td>be offered, hydration levels, provide food and drinks</td>
<td>clinician (Required), Ward Manager, Matron, MDT can also consist of OT, Psychologist, ERT</td>
<td>Notify Clinical director and Head of Nursing.</td>
</tr>
<tr>
<td><strong>24 Hours (Out of hours)</strong></td>
<td>Senior MDT Review</td>
<td>Full NEWS to be offered, hydration levels</td>
<td>On call consultant, Nurse in charge, Bed Manager supervising member of staff, ERT.</td>
<td>Duty Doctor (If On call Consultant not available)</td>
</tr>
<tr>
<td><strong>72 Hours (Monday – Friday 09:00-17:00)</strong></td>
<td>Director MDT Review</td>
<td>Full NEWS to be offered, hydration levels</td>
<td>Responsible clinician (Required), Ward Manager, Matron, MDT can also consist of OT, Psychologist, ERT</td>
<td>Covering consultant (If Responsible Clinician not available)</td>
</tr>
<tr>
<td><strong>72 Hours (Out of hours)</strong></td>
<td>Director &amp; MDT Review</td>
<td>Full NEWS to be offered, hydration levels</td>
<td>On call consultant, Bed Manager, Nurse in Charge, ERT</td>
<td>Duty Doctor (If On call Consultant not available)</td>
</tr>
</tbody>
</table>

This schedule should be repeated every 24 hours and the Director & MDT review repeated every 72 hours. Notify Matron, Clinical director and Head of Nursing as soon as possible during working hours.
Terminating of Seclusion

6.62 Seclusion should be terminated immediately when it is determined that it is no longer warranted [MHA CoP, 26.144]. It can be ended by;
- The nurse in charge of the ward in consultation with the patient’s Responsible Clinician or duty doctor (either in person or by telephone)
- Following an internal or independent multi-disciplinary review
- Following a medical review

6.63 Opening a door for short periods (e.g.: to access toilet or bathing facilities, food breaks, access to secure outside space, or medical, nursing or MDT reviews) does not constitute an end to seclusion [MHA CoP 26.146]. The nurse in charge of the ward should ensure that there is a care plan in place, informed by a risk assessment, for the safe management and support of the patient on the ending of seclusion [MHA CoP 26.148].

Phased re-integration

6.64 In some cases, it may be necessary to have a phased reintegration back into the ward environment before seclusion has ended. This allows the patient to be observed and risk assessed prior to full integration to the ward. Medical and nursing staff must together draw up a plan on how the patient is going to be best integrated back into the ward area.

- This approach provides a managed step down from seclusion for the patient, providing opportunities for the patient to be nursed in a less restrictive environment, whilst offering staff the opportunity to further assess whether continued seclusion is warranted
- A step-down plan must be fully recorded in the patient record, care plan B and the seclusion record including the rationale, objectives and the benefits of using this approach rather than integrating them immediately back onto the ward environment.
- Whilst using the step-down approach the patient is still regarded as secluded, and the documentation will continue until the seclusion has ended.

6.65 Following all episodes of seclusion there should be a post-incident review/de-brief to ensure organisational learning and support for all parties involved, including patients.
6.66 Patient Engagement and Experience

- All patients should have a positive behavioural support plan or crisis support plan and be encouraged to participate in the development of such plans if capable and willing to do so. It would be beneficial to summarise this information into a summary which is easily accessible.

- Patients should be encouraged to make an advanced statement with respect to the use of restrictive practices if capable and willing to do so. A copy of this policy should be readily available to patients on request.

- The safeguarding lead for the trust should be informed whenever a patient makes a complaint about the use of seclusion or long-term segregation [MHA CoP 26.171]

- Whenever possible patients should be encouraged to participate in the development of the seclusion care plan, this should be evidenced in the patient’s healthcare record.

- Unless clinically contra-indicated, the patient should be given a copy of the seclusion care plan. If contra-indicated, the reasons for same must be clearly recorded in the patient’s healthcare record.

- Following the use of seclusion the patient should be supported and given the opportunity to participate in a de-brief process to help them understand what has happened and why [MHA CoP 26.167]. If the patient is able and willing then this should be undertaken by someone of the patient’s choice [MHA CoP 26.169]

- If a patient is not able or willing to participate in a de-brief process then assessments of the effects of the use of seclusion on behaviour, emotions and clinical presentation should be undertaken and recorded in the patient’s positive behavioural support plan/crisis support plan [MHA CoP 26.168]

- If willing or able, the patient’s account of the incident giving rise to the use of seclusion, including feelings, anxieties or concerns, should be documented in their healthcare record [MHA CoP 26.170]

Medication

6.67 There is no expectation that additional medication will be given whilst a patient is in seclusion. However, where the administration of additional medication is required then oral medication should be offered before parenteral medication.

6.68 If additional oral or parenteral medication has been administered within approximately 30 minutes prior to seclusion it must be brought to the attention of the attending doctor and senior nurse attending and the details recorded clearly.
6.69 Where it is necessary to prescribe and/or administer emergency oral or parenteral medication, or in exceptional circumstances intravenous medication, to patients in seclusion, this will be considered a medical emergency requiring the presence of a doctor and senior nurse/manager on duty.

6.70 If the patient is detained under the Mental Health Act 1983, any prescribed medication must be administered within the legal framework of that Act (with specific reference to Part 4, sections 58 and 62) and in line with the Trust ‘Policy and procedure for the use of rapid tranquillisation’.

6.71 Note that if the patient is not eligible for treatment under Part 4 of the Mental Health Act, authority to treat may be granted either under the common law or the Mental Capacity Act, dependent upon the circumstances. In such circumstances where the patient is not detained under the Mental Health Act, medical staff are advised to seek legal guidance regarding treatment prior to medication being prescribed or administered.

6.72 Emergency equipment must be immediately to hand whenever it is deemed necessary to administer emergency parenteral (or IV) medication to a patient in seclusion.

6.73 If a patient in seclusion has been sedated or received emergency parenteral (or IV) medication then a care plan will be formulated to monitor the physical condition of the patient. This should be in accordance with the Trust ‘Policy and procedure for the use of rapid tranquillisation’ and include

- The monitoring of the patient’s blood pressure, temperature, pulse, respiration, degree of movement and response to verbal or tactile simulation

- Attempts, whether successful or not, to measure the patient’s vital signs must be recorded on a BP/TPR chart and in the patient’s healthcare record

6.74 If a patient has been sedated then they should be monitored ‘within eyesight’ observation by a qualified nurse, until such time as a medical review indicates otherwise [MHA CoP 26.122]

6.75 There is no requirement to have a doctor present at the time of, or post administration of a pre-prescribed/regular parenteral depot preparation to a patient in seclusion. However, to ensure the highest standards of care in the administering of parenteral depot medications to seclusion patients all patients who require this should have a care plan that specifically addresses physical care needs during and post administration of the depot. This care plan should make specific reference to

- Requirements for the post administration monitoring of the patients physical condition
- Identification of any known physical risks or potential adverse reactions, and the control measures to be employed to minimise and manage these.
• Identification of personnel required to be present both during and post administration of the depot to manage any potential adverse physical reactions, active patient resistance, or increased arousal or agitation at the time of administration.

Self Harm

6.76 The Trust recognises that at times patients who may require seclusion also present with risks of self-harm. On such occasions patient management will be in accordance with Chapter 26.108 of the Code of Practice which states that “where the patient poses a risk of self-harm as well as harm to others, seclusion should 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 arising from their own self-harm and that any such risk can be properly managed”.

6.77 The decision and rationale for secluding a patient with a known risk of self-harm should always be fully recorded within a care plan that identifies measures to manage any potential self-harming behaviour.

Visits

6.78 The code of practice recognises that for patients who are in seclusion for a prolonged time visits may be appropriate [MHA CoP 26.111] following an assessment of risk. In such cases the visit will be in accordance with the appropriate visiting policy for the particular service.

6.79 Official visitors should consult with the nurse in charge of the ward before visiting a secluded patient. It would be prudent, in cases of concerns for the visitor, for the nurse in charge of the ward to consult with the Responsible Clinician or their nominated deputy, or the senior nurse on duty if there is concern that a visitor may be at risk.

6.80 The conditions under which visits take place for patients in seclusion will be determined by the nurse in charge of the ward in consultation with the Responsible Clinician or deputy, and/or the senior nurse on duty.

6.81 Prior to any visit taking place the nurse in charge will ensure that the visitor is made aware of the conditions under which the visit will take place and the reasons for any restrictions placed upon it.

6.82 If a visitor is not satisfied with the conditions under which the proposed visit will be facilitated then the nurse in charge should liaise with the senior nurse/manager on duty prior to the visit commencing. The decision of the senior nurse/manager will be final.

Appeal

6.83 If a patient or patient’s representative wants to make any representation regarding the use of seclusion it should be made to the Medical Director, or the Medical Director’s nominated deputy, who will conduct a formal review, taking into account all representations as well as all the circumstances before making a decision.
Long – Term Segregation (LTS)

6.84 The Trust recognises that on rare occasions, it is permissible to not allow a patient mix freely with other patients on the ward or unit on a long-term basis in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation. (MHA CoP, 26.150-151),

“In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement is that, if the patient was allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time”. (MHA CoP, 26.150)

Consideration and Initiation of LTS

6.85 When a patient is being considered for LTS, a multi-disciplinary team which should include an IMHA in cases where the patient has one, must consider it necessary, and a representative from the responsible commissioning authority should be involved in the decision to initiate LTS. Wherever appropriate, the views of the patient’s family and carers should be sought and taken into account (MHA CoP, 26.150).

“The local safeguarding team should be made aware of any patient being supported in LTS” (MHA CoP, 26.153) and the following should also be involved in the discussion and decision to use LTS:

- Executive Director of Nursing and Quality
- Positive and Safe Group Chair
- Trust Reducing Restrictive Practice/Violence Reduction Lead

6.86 Ordinarily a patient will not be placed straight into LTS without going into seclusion first, but this may be considered necessary in some circumstances. LTS should be considered where a patient has had a lengthy period of time in seclusion or when reintegartion from a period of seclusion to the ward environment has proved unsuccessful after a number of attempts and it becomes evident that a slower reintegration plan is required to maintain the safety of others.

6.87 Where a patient has been in seclusion continuously for 7 days or, secluded more than 3 times over a 7 day period, then LTS should be considered. The review by the MDT will consider if the period of seclusion will be:

- Continued as Seclusion
- Discontinued and patient allowed to mix freely with others in the ward environment
- Seclusion is discontinued and LTS commenced.
Conditions of LTS

Patients in LTS should be cared for in conditions of least restriction necessary to maintain safety [MHA CoP 26.151], i.e. the environment must not be more restrictive than is necessary. The restrictions should be detailed within the patients care plan. Patients should be cared for under the following conditions:

- Should at a minimum have access to a bedroom, bathroom facilities, a relaxing lounge area, secure outdoor areas, therapeutic interventions and a range of activities of interest and relevance to that patient. This can be carried out by either a qualified or unqualified member of staff who has the suitable skills to carry out this role.
- Should not be isolated from contact with staff.
- Should be supported through enhanced 1:1 observations at a minimum at all times. Should have a written record of the patient’s behaviour and presentation hourly, kept by the member of staff carrying out the enhanced observations.

At times of acute behavioural disturbance causing increased risk behaviour during a period of LTS, it may become necessary to contain an immediate risk of harm to others by transferring the patient to a physical area or conditions that are more secure and restrictive which are for the purpose of seclusion. In such situations, LTS ends and the procedure for seclusion should be followed. This must be used for the shortest time necessary to mitigate risk.

LTS Care plan must:

- Identify risks and articulate why long-term segregation is necessary
- Summarise the planned treatment/care/activity
- Specify the observation levels required.
- The conditions under which long-term segregation may be terminated
- Any chronic medical conditions presented by the patient
- Patient involvement and views
- Views and involvement of family/carers where appropriate
- Potential use of a crisis support plan
**Long - Term Segregation Reviews**

6.91 The purpose of reviews for patients in LTS is to determine whether the ongoing risks have reduced sufficiently to allow the patient to be re-integrated into the wider ward community, and to check on their physical and psychiatric wellbeing. The decision to terminate long-term segregation should be made by the patient’s multi-disciplinary care team following risk assessment. The patient’s IMHA should be involved in this process where available [MHA CoP 26.157].

**Nursing**

6.92 Patients in long-term segregation will be seen by the nurse in charge of the ward at each shift handover. The aim of this is to ensure that the patient’s health and wellbeing are evaluated and that the current presentation and mental state are assessed to ensure their needs are being met. A written entry will be made into the healthcare record by the nurse in charge on each occasion.

**Medical**

6.93 Patients in long-term segregation will have their situation formally reviewed by a Responsible Clinician at least once in any 24hr period [MHA CoP 26.155]. When the duty doctor is not an approved clinician he/she will always have access to a responsible clinician and will discuss the situation with the responsible clinician (or covering responsible clinician) and document that this has occurred. The timing of this will be determined by the clinical team. The purpose of the reviews is to assess mental state, behaviour and risk so as to better inform the MDT reviews. They are also to ensure that the patient’s physical healthcare needs are addressed. The details of these medical reviews will be recorded in the LTS record.

The reviews are not for the purpose of reviewing the use of LTS with the view to terminate it. Should there be any indication in the patient’s presentation during these reviews that suggests LTS should be reviewed, then a full MDT review must be convened within 24 hours by the patient’s Responsible Clinician, MDT, senior nurse and include an IMHA where appropriate.

**MDT Review**

6.94 Patients in long term segregation will be reviewed weekly by their multi-disciplinary care team. This review should include an IMHA where appropriate. [MHA CoP 26.155]

**Independent Senior Professional Review**

6.95 There is a need for periodic reviews of patients in LTS by a senior professional not involved in the case [MHA CoP 26.155]. This function will be provided by the Chair of the Positive and Proactive Care Group or a nominated deputy of appropriate seniority, with reviews being at periods of no longer than monthly. The responsible commissioning authority will be kept informed of the outcomes of these monthly reviews. [MHA CoP 26.155]

**External Reviews**

6.96 Whenever long-term segregation lasts longer than 3 months there should be regular three monthly independent reviews by an external hospital, which should include a discussion with the patient’s IMHA (if they have one) and representative of the local commissioning authority [MHA CoP 26.156].
Termination of LTS

6.97 Any decision to terminate LTS must be made by the MDT following a thorough risk assessment. The patient should be supported with reintegration back into the ward environment and to mix freely with others. The patient must be offered a debrief as soon as is practically possible following the termination of LTS. Risk assessments and care plans should be reviewed accordingly.

7. TRAINING

7.1 The Trust will provide training and supervision to support staff with differing degrees of specialism and seniority to maintain the competence associated with their role.

Staff involved in restrictive intervention and in implementing and supporting patients in seclusion must receive training to a level of basic life support and be fully aware of restraint related risks, seclusion safeguards, and medical emergency procedures. They must have read and have a good understanding of the trust engagement of observation policy and must have received training in Conflict resolution and breakaway techniques.

8. DISSEMINATION AND IMPLEMENTATION ARRANGEMENTS

8.1 The policy is available to all staff on the Trust Intranet. Managers will ensure that all staff are briefed on its contents and on what it means for them. Any enquiries regarding the implementation of this policy should be directed to the Clinical and Corporate Policy Manager.

9. SECLUSION AND LTS MONITORING ARRANGEMENTS

9.1 The Trust will have a robust seclusion and LTS monitoring process as part of its governance arrangement to ensure that it is taking “all reasonable steps to prevent the misuse and misapplication” of seclusion and LTS [MHA CoP 26.5]. This process will be overseen by the Positive and Proactive Care Group Chair and led by the Trust Reducing Restrictive Practice (RRP) Lead or a nominated individual.

9.2 The Positive and Safe Group and the RRP Lead will:

- Monitor the adherence of seclusion and LTS to the Code of Practice and any departures from it
- Receive and analyse data relating to, and monitor overall trends in, the use of seclusion and LTS
- Submit reports to clinical teams and management teams as required
• Review documentation for the collection of information about the use of seclusion and alternative management strategies
• Consider any staff training and education issues and make recommendations to the management team/committee
• Monitor the use of protective bedding/clothing
• Monitor the use of seclusion for race, gender and age
• Review difficult cases through case presentations with the teams
• Share and disseminate good practice

10. ROLES AND RESPONSIBILITIES

10.1 Ward Managers
• Conduct seclusion reviews as required by policy
• To ensure that all staff have an awareness of seclusion and the required safeguards in place
• That the use of seclusion is reported through the appropriate channels
• Seclusion use on the ward is reviewed and audited
• The use of seclusion is monitored and any concerns are escalated to senior management team

10.2 Responsible Clinician (RC)
• Responsible clinicians, including duty Consultant Psychiatrists, are responsible for liaising with Ward’s nursing team and leading medical reviews
• Reviews should take the form of focused clinical assessments with a particular emphasis on mental state, risks, medication and physical health.
• Ensure that the goal of the review is to end seclusion at the earliest time consistent with maintaining the safety of the patient in seclusion, other patients on the ward and staff.
• Responsible Clinician has oversight responsibility to ensure that medical reviews are being conducted and recorded accordingly
• Responsible Clinicians has responsibility to work with Ward Managers and Matrons to ensure that the policy is being implemented by all staff
10.3 Nurse in Charge (NIC)
- Conduct seclusion reviews as required by policy. Be an active member in clinical decision making regarding the use of seclusion and plans to reduce this restrictive intervention.
- Provide a handover to all staff that are conducting the seclusion review.
- Ensure that all senior members of staff outside of the ERT are aware of the need to attend a seclusion review.
- Ensure all documentation for seclusion, care planning, risk assessment, medication and physical health has been completed.
- Ensure that a member of staff assessed to have the required clinical competence is allocated to provide continual observations to the patient.
- Ensure that the continual observations of the secluded patient are rotated amongst the staff members assessed to have the required clinical competence.
- That the patient’s next of kin has been informed that seclusion has been commenced and of their rights to visit the patient.
- Ensure that a physical health assessment is offered covering all parameters of NEWS.
- Provide a handover to the oncoming shift of the patient in seclusion and what interventions have been offered and what the seclusions goals are for the patient in order for seclusion to be terminated as quickly as possible.
- Inform the Bed Manager/Duty Doctor if a patient has had to be placed in Seclusion.
- Has overall responsibility and accountability of Nursing care for the patient out of hours.

10.4 Bed Manager
- The primary function is to maintain site safety at all times. Other functions and responsibilities are secondary to this key principle.
- Outside of the hours of 09:00 - 17:00 the Bed Manager assumes the role of senior nurse for all seclusion reviews and must be present for each review that takes place as indicated by table 1.
- Conduct seclusion reviews as required by policy. Provide leadership in the decision making regarding the ongoing seclusion of service users and plans to reduce this restrictive intervention.
- Make joint decisions with the reviewing teams on PRN medication to be administered.
  - Manage and organise the ERT members when a seclusion review is due.
  - Provide a single point of contact for escalation of issues to the Silver on-call manager / Duty Doctor.
Divert resources where necessary to ensure the ongoing safe use of seclusion

10.5 Duty Doctor

- Outside of the hours of 09:00 - 17:00 the duty doctor assumes the role of Responsible Clinician (Unless otherwise stated in table 1) for all seclusion reviews and must be present for each review that takes place as indicated by table 1.
- Conduct seclusion reviews as required by policy. Provide leadership in the decision making regarding the ongoing seclusion of service users and plans to reduce this restrictive intervention
- Immediately review any patient who has been secluded outside of a seclusion environment
- Review medication of patient and make joint decisions with the reviewing teams regarding use of PRN medication
- Offer a full physical health assessment of the patient incorporating NEWS indicators
- If a decision is made that continued Seclusion is likely to pose a significant risk to the patient’s physical health then the Duty Doctor has the overall deciding authority to terminate seclusion
- Provide a handover to the oncoming Duty Doctor of the patient in seclusion, including what interventions have been offered and what the seclusions goals are for the patient in order for seclusion to be terminated as quickly as possible

10.6 Matron

- Conduct seclusion reviews as required by policy. Provide senior leadership in the decision making regarding the ongoing seclusion of service users and plans to reduce this restrictive intervention
- Divert resources where necessary to manage a patient outside of seclusion as soon as it has been identified that the patient no longer requires seclusion
- Immediately review any patient that has been secluded outside of the seclusion environment
- Liaise with bed management in order to move any patient secluded outside of seclusion environment into a seclusion environment
- Be aware of all patients in their service that have been secluded and arrange for a review of the patient as directed by table 1
- Escalate to the clinical Director any patient that has been in seclusion for over 24 hrs.
10.7 Clinical Director (Acute Division)

- To have an overview and knowledge of a patient secluded for over 24hrs.
- During working times to have a review of care with the Matron or Responsible Clinician regarding the management of the service user.
- Where possible to attend reviews as scheduled in table 1.

10.8 Staff member supervising the secluded patient

- Conduct seclusion reviews as required by policy. Be an active member in decision making regarding the ongoing seclusion of service users and plans to reduce this restrictive intervention
- The supervising staff must have been assessed as clinically competent to complete seclusion observations by the nurse in charge
- Where possible should always be a permanent member of staff with previous knowledge of the patient

10.9 Emergency response team Member

- Ensure that you are available to attend to alarm activations immediately and attend as quickly as possible. It is not acceptable to delay response to an emergency call as this may place service users, staff and visitors at risk
- Obtain a brief handover from the requesting ward team on attending any incident
- Provide support to the service initiating the request for the ERT under the leadership of the DSN or nurse in charge (Including seclusion reviews)
- Ensure alarm handset remains on their person
- If the ERT member is unable to respond to requests for the ERT team at any time during your shift (i.e. you are on a break), you must ensure that prior to being unavailable, your response alarm is handed over to an appropriately trained and competent individual, allocated by the NIC
- You must inform the NIC when you have taken back responsibility for the response alarm

10.10 Documentation and incident reporting

*Seclusion documentation occurs in two forms, as follows:*

- Seclusion observations
- Seclusion Review
The seclusion observation form is the main document, a new form should be started at the start of a new calendar day. Information on how to use this form can be viewed using this link: https://youtu.be/lbSFkISQGmY

The seclusion review form is an associated document to the seclusion observation form. A new seclusion review form must be completed for every review that is completed.

You must link the review to the observation document for the same date that you are completing the review.

Information on how to use this form can be viewed using this link: https://youtu.be/oNDVOdjiQ6Y

10.11 Seclusion observation by staff member supervising the secluded patient:

- The supervising member of staff is required to have direct eyesight of the patient at all times
- They are required to assess and record the wellbeing of the patient 4 times an hour. The observation record must include:
  - Respiratory rate
  - Conscious level
  - Food and fluid intake
  - Brief summary of any concerns
- The information must be documented into the seclusion document on care notes
- The supervising member of staff must complete their documentation prior to handing over the observations to another member of staff

10.12 Seclusion Review

- A nursing review must be documented by the most senior nurse present, as soon as possible and before the next review takes place
- The medical review form must be completed by the most senior medic present and should be completed as soon as possible and before the next review takes place
- Medical documentation must include the following items:
  - If this is a medical, nursing or MDT review
  - The physical health assessment of the patient (NEWS)
  - The patients current mental state
  - Any medication given
  - Any changes to the patient seclusion plan
  - Justification to continue seclusion if required
- MDT Reviews must be completed using the same guidelines as medical reviews.
10.13 Incident reporting

Documentation is required for all incidents involving a response from the ERT. Incidents will be documented on the DSN shift record, on Datix, and on the service user’s clinical records on CareNotes (progress notes/care planning/risk assessment)

You are only required to Datix the commencement of seclusion

10.14 After seclusion review

A review must be completed at the end of a seclusion review, this does not need to take the form of an AAR but should include the following points

- Reasons for continuing or terminating seclusion
- Seclusion goals in order to terminate seclusion
- Care plan for patient after the immediate termination of seclusion
- Time of next planned reviews and who must be informed

All the decisions made must be communicated to the patient by the Senior Nurse and Responsible Clinician
### MONITORING AND AUDIT ARRANGEMENTS

<table>
<thead>
<tr>
<th>Elements to be monitored</th>
<th>Lead</th>
<th>How Trust will monitor compliance e.g. Audit, checklist, dashboard</th>
<th>Reporting Frequency</th>
<th>Reporting and Monitoring Which committee or group will be responsible for scrutinising reports and monitoring outcomes.</th>
<th>Implementation of Lessons Learnt</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Seclusion and LTS Quality Audit</strong></td>
<td>Ward Manager</td>
<td>Audit via CareNotes</td>
<td>Monthly</td>
<td>Positive and Proactive Care Group</td>
<td>All changes will be agreed via Positive and Proactive Care Group and implemented by the ward managers for PICU</td>
</tr>
<tr>
<td><strong>Seclusion and LTS use audit</strong></td>
<td>Head of Nursing (Acute) Reducing Restrictive Practice Lead</td>
<td>Audit via Datix</td>
<td>Monthly</td>
<td>Positive and Proactive Care Group</td>
<td>All changes will be agreed via Positive and Proactive Care Group and implemented by the ward managers for PICU</td>
</tr>
</tbody>
</table>
11. REVIEW OF THE POLICY

This policy will be reviewed in March 2021 or earlier should a significant change in regulation or practice came to light.

12. REFERENCES

- National Association of psychiatric intensive care and low secure units (NAPICU)(2014) National Minimum Standards for Psychiatric Intensive Care in General Adult Services (Online)
- National Institute of Health and Clinical Excellence (2015) Violence and Aggression: Short Term Management in Mental Health and Community Settings. (Online) Available at: https://www.nice.org.uk/guidance/ng10
- Royal College of Nursing (2016) Positive and Proactive Care: Reducing the need for restrictive interventions (Online) Available at: https://www.rcn.org.uk/professional-development/publications/pub-005459

13. ASSOCIATED DOCUMENTS

- Responding to the physically deteriorating patient (inpatients)
- Positive management of violence and aggression
- Incident reporting
14. GLOSSARY

**Approved Clinician** - A mental health professional approved by the Secretary of State or a person or body exercising the approved function of the Secretary of State, or by the Welsh ministers, to act as an approved clinician for the purposes of the act. Some decisions under the Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.

**Association** - this refers to any time when the patient is escorted outside the seclusion room/area, possible in the company of other patients, as part of an assessment of whether or not seclusion should end.

**Independent Multi-Disciplinary Team** - a professional team including staff from a range of different professions.

**Internal Multi-Disciplinary Team** - the multi-disciplinary team normally responsible for providing and prescribing individual care to the patient.

**Positive Behavioural Support Plans** - individualised care plans should be developed with the services user and should be available to staff, kept up to date, and should include primary preventative strategies, secondary preventative strategies and tertiary strategies informed by a functional analysis.

**Responsible Clinician** - the approved clinician with overall responsibility for a patient’s case. Certain decisions (such as renewing a patient's detention or placing a patient on a community treatment order) can only be taken by the responsible clinician.

**Senior Nurse/Senior Manager/Duty Manager** - these terms may be used interchangeably and be locally determined. It is expected that this would be a qualified professional with suitable experience of Band 7 or above.

**Advanced Statement** - a statement made by a person, when they have capacity, setting out the person’s wishes about medical treatment. The statement must be taken into account at a future time when that person lacks capacity to be involved in discussions about their care and treatment. Advanced statements are not legally binding although health professionals should take them into account when making decisions about care and treatment.

**Sight and sound** - there must be a staff positioned within eyesight of the seclusion room. The positioning of the staff must be such that they would be likely to hear the patient should they attempt to summon staff attention.

**Suitably skilled professional** - a member of clinical staff who has knowledge of the seclusion policy, the specific clinical environment, and the specific needs of patients whilst in seclusion. They need not hold a formal disciplinary or academic qualification but must be aware of the specific risks and care needs of the patient they are providing care for.
15. APPENDICES

Appendix 1

15.1 Equality Impact Assessment Tool

<table>
<thead>
<tr>
<th></th>
<th>Does the policy/guidance affect one group less or more favourably than another on the basis of:</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Is the impact of the policy/guidance likely to be negative?</td>
<td>Yes</td>
<td>Seclusion can cause trauma and replay trauma</td>
</tr>
<tr>
<td>5.</td>
<td>If so can the impact be avoided?</td>
<td>No</td>
<td>Seclusion is an intervention that is used as an absolute last resort to keep people safe from harm. When it is used, it means that the risk to others outweighs the negative impact of its use.</td>
</tr>
<tr>
<td>6.</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td></td>
<td>Use of other least restrictive options where a person presents with risk of violence to others. For example, physical restraint and pharmacological intervention</td>
</tr>
<tr>
<td>7.</td>
<td>Can we reduce the impact by taking different action?</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2

15.2 Debrief Flow Chart

- Incident occurs and Team arrives to manage incident
  - Bed Manager, Duty Doctor and Response Staff, Response Alarms sound giving them location of Alarm
  - Incident is managed by staff, Bed Manager arranges for all staff informed to attend the Debrief

- Insure staff and patient safety is in place at beginning of Debrief
  - Patient is placed on observations and provided medical assessment if necessary
  - Staff are checked for injuries and medical assessment is provided if necessary

- Debrief
  - See Debrief Model

- Complete actions generated from Debrief
  - Bed Manager to ensure that following actions are completed immediately post debrief: Physical Health observation, Observation Level
  - Duty Doctor to ensure following actions are completed post debrief: medication review, medical review

- Datix Completed
  - Bed Manager sends debrief to handler for this to be added to the Handler section of Datix
  - Ward Staff Update: Care notes Risk assessment and ISP, relatives to be informed of the incident

- Specialist lead and Positive and proactive group to review debriefs (trends and concerns)
  - PMVA Lead to review handler sections and feedback narrative to Pos & Pro Group
  - PMVA Lead to email managers of incidents that require further investigation
Appendix 3

15.3 Patient rights

Whilst in seclusion you can expect the following:

- To be treated with respect and dignity at all times
- To be told why you have been placed in Seclusion
- To been told what needs to be achieved in order for Seclusion to be terminated
- To be able to see what time and day of the week it is via a clock
- To know what time each review is and who will be present
- A nurse should be observing you all times, that you can talk to
- You will receive regular meals, drinks and snack
- You will have access to toilet and washing facilities
- You will remained clothed at all times
- You will have your requests granted where possible
- You will be able to send messages to anyone you wish to contact
- You may be granted use of the ward mobile phone
- We can play music for you
- You may be granted items to occupy yourself based a discussion with the Nurse in Charge and Doctor