Policy:

NPCS 009 Seclusion

Including guidance for long-term segregation where facilities exist

Executive Director lead	Executive Director of Nursing, Professions and Care Standards
Policy author/ lead	Head of Mental Health Legislation
Feedback on implementation to	Restrictive Interventions Group

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Target audience	All SHSC staff (including staff seconded into or working in SHSC services) working in settings where seclusion may be practised.

Keywords	Seclusion, observation, review, record-keeping

Policy Version and advice on document history, availability and storage
Version 6 of the Seclusion Policy

This policy provides staff with the information they require safely and lawfully to seclude patients, to review seclusion and to terminate seclusion as required by the Mental Health Act Code of Practice 2015

This version was reviewed and updated in order to: remove some unnecessary content; clarify the review of seclusion schedule; clarify which staff are authorised to carry out reviews; identify which reviews can substitute for other reviews; include a contingency for nursing reviews when only one nurse is present, obviate the need for the seclusion pack; use the term 'patient' in keeping with the MHA Code of Practice, (the source of the policy) and to remove redundant appendices.
This policy is stored and available through the SHSC intranet and internet. This version of the policy supersedes the previous version (V5, ratified May 2017 2017). Any copies of previous versions of the policy and its accompanying seclusion pack held separately should be destroyed and replaced with this version.

Contents

Seclusion Flow-Chart

Trigger for Seclusion

There is severe behavioural disturbance which is likely to cause harm to others & de-escalation has been unsuccessful or it is not safe to attempt

Seclusion Review Schedule

Box A: FIRST MEDICAL REVIEW

This is required **within 1 hour, or without delay if the patient is newly admitted or if there has been a significant change in the patient's physical, mental state and/or behavioural presentation,**

1. During office hours the Medical Reviews are to be conducted by RC, other doctor from ward MDT, or any available doctor. 2. Outside office hours, contact the **duty doctor in the first instance**

If seclusion was authorised by a consultant psychiatrist, this counts as the first medical review. See para 6.3.2 of this policy for the escalation process if there are difficulties achieving the1 hour time limit

Box B: Commence 4-Hourly Medical Reviews and 2-Hourly Nursing Reviews

Medical Reviews continue 4-hourly until the first Internal MDT Review

1. During office hours the Medical Reviews are to be conducted by any ward doctor or any available doctor
2. Outside office hours the Medical Reviews are to be conducted by the **duty doctor**

Nursing Reviews continue 2-hourly throughout seclusion unless the patient is sleeping at night.

If the patient is sleeping at night (ie between 22.00 and 08.00) the reviewing doctor and the nurse in charge of the ward may agree to omit or delay a review. The revised arrangements **must be documented**

A Medical Review may be combined with a Nursing Review.

Box C: Commence Internal MDT Reviews

First Internal MDT Review as soon as practicable BEFORE 17.00 on the day following the commencement of seclusion (not between 22.00 and 08.00): continue thereafter on a daily basis

1. During office hours: To be conducted by the RC (or a doctor who is an AC) or, in exceptional cases, an SAS Doctor or a Higher Trainee, plus the senior Nurse on the ward and staff from other disciplines who are normally involved in the patient's care

2. Outside office hours At least a senior doctor (**higher trainee/SAS doctor in the first instance** – if unavailable then the on-call consultant) plus the senior nurse on the ward. Inform the on-call manager of the review and the outcome.

The Internal MDT may call for an Independent MDT review at any time.

An Internal MDT Review outside office hours may constitute the Independent MDT Review, see below

An MDT Review constitutes 1 Medical Review and 1 Nursing Review

Box D: Medical Reviews reduce to AT LEAST twice in every 24-hour period of continuous seclusion

1. During Office Hours at least one Medical Review to be conducted by the RC or, exceptionally by a senior doctor (**higher trainee/SAS doctor**)

2. Outside office hours at least one Medical Review to be conducted by a senior doctor (**higher trainee/SAS doctor** in the first instance – if unavailable then the on-call consultant). This would usually be an MDT review.

The second daily medical review is to be conducted as per Box B

Both Medical Reviews may take place during daytime hours (e.g. (9:30 and 16:30); there is no requirement for 12-hour intervals

A Medical Review may be combined with a Nursing Review

Box E: INDEPENDENT MDT REVIEWS

If seclusion persists for 8 hours consecutively or for 12 hours intermittently during a 48-hour period, an Independent MDT Review is triggered.

The first Independent MDT Review is required as soon as is practicable BEFORE 17.00 on the day following a trigger (not between 22.00 and 08.00); it is not required the moment it is triggered

At this review, a further Independent review must be scheduled within the next 7 days; this must be in office hours.

1. During office hours: a doctor who is an AC (or in exceptional circumstances an SAS Doctor or Higher Trainee) and the senior nurse on the ward MUST attend, with members of the wider MDT plus the patient's IMHA (if he or she has one) also invited. Attendees should not have been involved in the incident leading to seclusion.

2. Outside office hours Conducted by a senior doctor (higher trainee/SAS doctor in the first instance – if unavailable then the on-call consultant and the senior nurse on the ward. The Independent MDT Review would replace the internal MDT review.

Clinical Director to be informed if seclusion not terminated and of the date for next Independent Review

An Independent MDT Review constitutes 1 Internal MDT, 1 Medical Review and 1 Nursing Review

1. Introduction

The NICE Guidance relating to the management of violence and aggression *(NICE guideline NG 10, 2015)* indicates that restrictive interventions should be used if de-escalation and other preventive strategies, including p.r.n. (as required/when needed) medication, have failed and there is potential for harm to the patient or other people if no action is taken. The intervention selected must be a reasonable and proportionate response to the risk posed by the patient.

SHSC Staff work in settings where seclusion may be needed to manage incidents of severe behavioural disturbance which is likely to cause harm to others.

Seclusion should only be used in hospitals and in relation to patients **detained** under the Mental Health Act 1983. 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.

Seclusion should not be used as a punishment or a threat, or because of a shortage of staff. It should not form part of a treatment programme.

Seclusion should never be used solely as a means of managing self-harming behaviour.

Where the individual 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 individual's health or safety and that any such risk can be properly managed.

(Mental Health Act Code of Practice 2015 Ch 26.106-26.108)

There are specific standards for the design of seclusion rooms in the Mental Health Act Code of Practice 2015 Ch. 26.109:

- the room should allow for communication with the patient when the patient is in the room and the door is locked, eg via an intercom
- rooms should include limited furnishings which should include a bed, pillow, mattress and blanket or covering
- there should be no apparent safety hazards
- rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
- rooms should have externally controlled lighting, including a main light and subdued lighting for night time
- rooms should have robust door(s) which open outwards
- rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
- rooms should not have blind spots and alternate viewing panels 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.

2. Scope

This policy applies to all SHSC staff, including bank/flexible workforce staff, and any other staff seconded into or working in SHSC services.

3. Definitions

Seclusion:
Seclusion refers to 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 the containment of severe behavioural disturbance which is likely to cause harm to others.

[Note that the room does not have to be locked]
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'; 'low stimulus'; 'open seclusion') or the conditions of the immediate environment do not change the fact that the patient has been secluded. It is essential that they are afforded the procedural safeguards of the Code.

Mental Health Act Code of Practice 2015 Ch 26.103-26.104

Severe Behavioural Disturbance:
Severe behavioural disturbance refers to behaviour that puts the person/patient or others at immediate risk of serious harm and may include threatening or aggressive behaviour or other actions likely (in the view of a Multi-disciplinary Team) to cause high levels of distress in others, and serious self-harm which could cause major injury or death.

Violence and Aggression:
Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

Violence and aggression: short-term management in mental health, health and community settings (NICE guideline NG 10, 2015).

De-escalation:
The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. P.r.n. medication can be used as part of a de-escalation strategy but p.r.n. medication used alone is not de-escalation.

Violence and aggression: short-term management in mental health, health and community settings (NICE guideline NG 10, 2015).

P.R.N Medication:
pro re nata - when needed. In this policy, p.r.n. refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or

aggression**.** It does not refer to p.r.n. medication used on its own for rapid tranquillisation during an episode of violence or aggression

Violence and aggression: short-term management in mental health, health and community settings (NICE guideline NG 10, 2015).

Rapid tranquillisation:
Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

Violence and aggression: short-term management in mental health, health and community settings (NICE guideline NG 10, 2015).

Manual restraint: (RESPECT techniques for manual restraint are used in SHSC)
A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent patients from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the patient.

Violence and aggression: short-term management in mental health, health and community settings (NICE guideline NG 10, 2015)

Suitably skilled professional:
One who has been adequately prepared for carrying out the continuous observation of the secluded person by being given sufficient clinical information about why the observation is necessary and what events or behaviours require intervention and/or to be recorded.

4. Purpose

The purpose of this policy is to ensure that when seclusion proves to be unavoidable the requirements of the MHA Code of Practice are maintained. The overarching rights of all patients are described in the Trust policy for Mental Health Act, Equality and Human Rights.

The Trust is committed to eradicating unnecessary restrictive interventions, therefore it is essential that all episodes of violence, aggression or other disturbed behaviour are fully documented in order to demonstrate that seclusion was both unavoidable and necessary.

5. Duties

The Chief Executive is responsible for ensuring that the systems on which the Board relies to govern the organisation are effective. The Statement of Internal Control is signed annually indicating that systems of governance, including risk management are properly controlled. The Trust's Chief Executive is responsible for keeping the policy updated and available for staff.

The Trust will, so far as is reasonably practicable, ensure that staff have the following:

- A safe system of work
- A safe working environment
- Adequate training, supervision and instruction
- Information relevant to the employee's safety at work

Directors and Associate Directors are responsible for ensuring that all Senior Operational Managers and Ward Managers in their areas are aware of the policy and support its implementation and that on-going leadership and co-ordination via a senior manager is provided to RESPECT Trainers. Directors/Associate Directors are also responsible for maintaining a suitably experienced clinical individual in a lead/co-ordination role for the continued implementation and maintenance of the RESPECT training programme. Directors/Associate Directors are responsible for delegating responsibility for risk assessing the level of resuscitation skills; training and equipment required in each service area (see SHSC Resuscitation Policy).

RESPECT Trainers are responsible for delivering training with regard to manual restraint and seclusion (as appropriate to job role requirements) within SHSC. Trainers will maintain their skills and knowledge base by annual updates, as a minimum. RESPECT Trainers should have up to date resuscitation training.

Senior Operational Managers (SOM) and Ward Managers are responsible for ensuring the implementation of the Seclusion policy within the ward environment/the team/the department that they manage. They must ensure that the policy is readily available to all staff at all times: if a paper copy is kept in the care area, the Ward Manager must ensure that it is an up-to-date version. SOMs and Ward Managers must ensure that the recording and auditing of incidents of seclusion is completed in line with this policy. SOMs and Ward Managers are also responsible for ensuring that there is a regular and comprehensive annual assessment of ligature risk and other safety measures to ensure the safety of the environment, in addition to the regular completion of the Health and safety Checklist for their area.

SOMs and Ward Managers are responsible for maintaining training and equipment levels in their ward. This will include ensuring that are staff appropriately trained to monitor physical health as per a risk assessment of the physical interventions that are likely to take place in that service.

Nurse (or other professional) in Charge of the Ward must ensure that all reviews decisions and actions take place and are appropriately recorded using the relevant documentation and relevant parties informed of incidents of seclusion in a timely manner. The shift coordinator/team leader may delegate these duties to other staff; however their completion remains the responsibility of the shift co-coordinator/team leader. The person in charge of the ward is responsible for ensuring that the seclusion room is kept locked when not in use, and checked for cleanliness, damage or other risk-related consequence after every use.

Responsible Clinician will review any patient who is involved in any episode of seclusion in line with the policy.

On-call Consultant The on-call consultant (who acts as RC for all detained patients out of hours) should be available out of hours for advice and supervision. Such contact is at the discretion of the doctor completing the medical review but not mandatory (unless medication under MHA s62 or major change of treatment plan is required)

Other Doctors The Trust has determined that all medical doctors, irrespective of grade, or level of registration will be considered competent to undertake medical reviews (including Higher trainee; Core trainee; Foundation doctor; General Practice Vocational Training Scheme; SAS; Consultant) if they meet the following criteria:

- have read this policy have access to the seclusion review schedule
- have access to senior medical advice at all times
- have access to senior nursing advice at all times.

Doctors' Roles in Review of seclusion

Duty Doctor – The duty doctor is the practitioner providing ward cover out of hours – aka 'SHO'. The duty doctor may undertake the first medical review and 4-hourly routine medical reviews.

Higher Trainee – aka 'SpR' or 'Registrar' or **SAS Doctor** – aka Staff Grade or Associate Specialist. A higher trainee:

- will undertake at least one of the out of hours medical reviews when these have been reduced to 2-hourly
- will undertake out of hours Internal MDT reviews
- will undertake out of hours Independent MDT reviews
- may undertake, in exceptional circumstances, office hours Internal MDT reviews
- may undertake, in exceptional circumstances, office hours Independent MDT reviews

Restrictive Interventions Group will review all restrictive interventions implemented in the organisation with a view to the eradication of unnecessary restrictive interventions, including seclusion.

All staff members within the scope of the policy are responsible for ensuring that their practice is safe. All staff members are required to ensure they, and anyone they line manage, abide by SHSC requirements as set out in this policy. Staff should act in ways that are consistent with any codes of practice relevant to their profession. The Trust has a duty of care towards its employees and towards patients, which is fulfilled by the implementation of this policy. Monitoring of incidents and the use of seclusion is essential and staff have a responsibility to ensure accurate and timely reporting of incidents.

Education, Training & Development Department will maintain a database of all staff who have undergone RESPECT Training.

6. Process

6.1 Commencing seclusion

6.1.1 Authorisation

Seclusion may be authorised by:

- The Registered Nurse in charge of the ward
- The Responsible Clinician (Consultant Psychiatrist if the patient is not currently detained)
- Any other doctor

During office hours, the RC should be informed of the seclusion as soon as practicable

Outside office hours, the duty doctor should be informed as soon as practicable. The duty doctor may inform the on-call Consultant Psychiatrist at his/her discretion

The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion.

6.2 Searching and Special Risk Clothing

Prior to leaving the patient in seclusion, a search of the individual's clothes and pockets, along with a 'rub down/pat down' search of the individual's person should take place to ensure that articles which could cause physical injury (including ligature) to the secluded patient or to staff delivering care are removed. A metal detecting 'wand' may further support such a search, which will be conducted as follows:

- The search, as described above, will take place on the authority of the person authorising seclusion
- It is not necessary to adhere to the authority to conduct searches as described in the Trust's policy for searching patients
- A minimum of 4 staff is required safely to carry out a search, (three to manually restrain the patient and one to conduct the search). More staff may be required, depending on the patient's presentation
- The search should be carried out by staff of the same gender as the secluded person wherever possible, with due regard for any possible re-traumatisation of potential victims of physical or sexual abuse
- Consent from the patient will be sought where possible but consent is not required
- Wherever possible, the patient should receive an explanation of the reason for their being secluded and for the search, and why there is authority (under this policy) to carry out the search and, if necessary, to remove items which may pose a risk, including personal effects, pocket contents, attire that might cause injury to self or others, and – if necessary - disability aids, see paragraph 6.19.
- Staff may decide what a patient can take into the seclusion area – this may include returning items at a later stage of seclusion, subject to patient presentation and risk assessment. A record should be made in the seclusion care plan of what is permitted in the seclusion area
- A list of any items removed from the individual should be made in the patient's

notes. The list should be signed and witnessed by 2 staff as an accurate record of the items removed
- If, in exceptional circumstances, Special Risk clothing is necessary to manage the risk of deliberate self-harm during a period of seclusion, a clear rationale for its use must be recorded in the patient's care plan. A detailed incident report must be submitted for each incidence of the use of Special Risk clothing.

The individual will remain under constant observations if staff believe that the secluded person is concealing a hazardous article, despite a search having been undertaken.

The secluded person should never be deprived of clothing when in seclusion

There must always be due consideration given to the person's privacy, dignity, cultural traditions and customs, subject to necessary risk management measures.

6.3 Observations and Record Keeping

6.3.1 Duties of the Nurse in Charge

Upon implementation of seclusion, the nurse in charge of the ward will immediately arrange for:

- A suitably skilled professional (ie one who has been adequately prepared for carrying out the observation of the secluded person by being given sufficient clinical information about why the observation is necessary and what events or behaviours require intervention and/or recording) to remain within sight and sound of the seclusion area at all times throughout the patient's period of seclusion
- Due consideration is to given to whether male or female staff are preferable. This may be informed by consideration of a patient's trauma history
- The observing staff to have the means to summon urgent assistance from other staff at all times
- The commencement of record-keeping
- The commencement of physical health monitoring, including the SHSC Early Warning Score
- The notification of relevant others, such as relative/care if agreed and appropriate (consider patient consent); on-call manager to be informed if necessary
- Noting any medication given prior to seclusion for the purposes of recognising when the maximum dose has been given in any one 24 hour period

6.3.2 Record Keeping – Commencement of Seclusion

Record keeping may be delegated to another staff member by the Nurse in Charge. Staff will complete seclusion records in the appropriate format (electronic or paper-based). This record should include:

- who authorised the seclusion
- the date and time of commencement of seclusion
- the reason(s) for seclusion

- whether physical restraint was utilised prior to or during the process of secluding the patient
- whether any medication was administered prior to or during the process of secluding the patient
- what the patient took into the seclusion room and what was denied/removed
- if and when a family member, carer and/or advocate was informed of the use of seclusion
- other staff (e.g. senior manager) who was informed

6.3.3 Record Keeping – During and on Termination of Seclusion

A contemporaneous record of the observations must be maintained by the suitably skilled professional as follows:

- At least every 5 minutes for the first hour of seclusion.
- Intervals of no more than 10 minutes after the first hour, subject to risk assessment

6.3.4 Content of records

The records made should include:

- the patient's appearance
- what they are doing and saying, including evidence of distress
- their apparent mood
- their level of awareness
- any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis
- where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate
- provision of medications, food and fluid, including reasons for provision of cold food, cooled drinks or other risk-mitigation actions
- provision of or access to washing or toilet facilities, including the reason for any restriction on these for risk-mitigation reasons
- the time and details of who undertook scheduled reviews, and details of the assessment and recommendations of the reviewers
- the time, reasons and details of all who enter the seclusion room during the period of seclusion
- the date and time seclusion ended, and details of who determined that seclusion should come to an end and their reasons

Detailed and contemporaneous records must also be kept in the daily record of the individual in the event of any use of seclusion; these would include the reasons for its use and subsequent activity.

6.4 Physical Health Monitoring

Following the seclusion of an individual, it is necessary to observe and assess the person's behaviour and wellbeing. It is essential that staff refer to the SHSC Physical Health Policy in order to access the Early Warning tool to support the monitoring of the physical health and wellbeing of the patient and readily to identify any adverse reactions to any interventions.

Monitoring of physical health may include non-contact 'ABCDE' observation, ie visual assessment of **A**irway; **B**reathing; **C**irculation; **D**isability; **E**xposure

N.B. An individual who has been physically restrained and/or has received rapid tranquillisation is at significantly higher risk of suffering adverse effects such as positional hypoxia or an adverse medication reaction.

6.5 Seclusion Reviews

A series of reviews must be instigated when a patient is secluded in order to 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.

NB In all circumstances, ensuring that reviews occur takes priority
Please refer to the review schedule flow-chart at page 4

In addition to the staff listed below for each type of review, consider the inclusion of RESPECT leads in seclusion reviews.

In the event that it is not possible to assemble sufficient staff to enter the seclusion room, or the range of professionals required to undertake a review as described in the flow-chart (p4) a review of the patient's presentation should still be made and on time.

Identify the time of the actual review in the record if the record is completed subsequent to the required interval.

An incident form must be completed if a review is late or omitted for any reason.

6.5.1 The First Medical Review

6.5.1.1 Newly admitted patient or significant change in presentation

If the patient is newly admitted, not well known to the staff, or there has been a significant change in the patient's physical, mental state and/or behavioural presentation, a medical review should take place **without delay**

- **Office hours:** This may be undertaken by the RC, another doctor from the ward MDT, or any other available doctor
- **Outside office hours:** contact the duty doctor in the first instance (see escalation process at 6.5.1.3)

6.5.1.2 Seclusion authorised by the Nurse in Charge of the Ward

If seclusion was authorised by the Nurse in charge of the ward, the first medical review must be undertaken **within one hour of the beginning of seclusion.**

- **Office hours:** This may be undertaken by the RC, another doctor from the ward MDT, or any other available doctor
- **Outside office hours:** contact the duty doctor in the first instance
- Securing the attendance of a doctor within 1 hour must be escalated as described below

6.5.1.3 Arranging a medical review within one hour outside office hours – escalation

1) Contact **on call Doctor** to request attendance for review of seclusion within an hour and note the time of this call
2) If the on-call Doctor has to prioritise another incident or does not respond to the call then contact the **on call Higher Trainee/SpR** to request attendance within the hour from the initial time of contact to the on-call Doctor
3) If the on-call SpR has to prioritise another incident or does not respond to the call then contact the **on-call Consultant** to request attendance within the hour from the initial time of contact to the on-call Doctor
4) If the on-call Consultant has to prioritise another incident or does not respond to the call then report this to the **on-call Senior Manager**

The Senior Manager for the service, or the on-call Service Manager (if out of hours) should also be contacted if either or both of the following apply:

- Difficulties are anticipated in providing for the appropriate level of care review (see below for review schedule)
- The Nurse in Charge or Medical Officer has due concern regarding the care to be provided to the secluded patient, or, the impact upon the care provided to the remaining patients/patients on the ward.

6.5.1.4 Seclusion authorised by a psychiatrist

If seclusion was authorised by a psychiatrist, whether or not they are the patient's responsible clinician or an approved clinician, the first medical review will be the review that they undertook immediately before authorising seclusion **(meaning that a medical review within one hour of seclusion is not necessary).**

If it is agreed that seclusion is to continue after the first medical review, a seclusion care plan should be agreed and prepared, see below at paragraph 6.11

Medical reviews then continue 4-hourly, until the first internal MDT review, see below at paragraph 6.8.2

6.6 Nursing Reviews

NB – seclusion may not be terminated by a nursing review; there must be consultation with and agreement from a doctor. This may take place by telephone

6.6.1 Schedule of nursing reviews

- All nursing reviews should follow the guidelines for a medical review, see below at paragraph 6.7
- Nursing reviews of the secluded patient should take place at least every two hours following the commencement of seclusion
- In the event that it is not possible to assemble sufficient staff to enter the seclusion room, a review of the patient should still be recorded on time. Identify the time of the actual review if the record is made subsequently beyond the 2-hourly interval.
- The MHA Code of Practice Chapter 26 paragraph 26.134) states 'nursing reviews should be undertaken by two individuals who are registered nurses, at least one of whom should not have been involved directly in the decision to seclude'. Nursing staff from other wards should be asked to assist in order to minimise the inclusion of staff involved in the decision to seclude
- In the event that only one registered nurse is on duty in a setting where it is not possible to secure the attendance of staff on duty on another ward, the nursing review must involve the Band 7 out-of-hours duty nurse, preferably in person.
- In exceptional circumstances, if the Band 7 duty nurse is unable to attend, the review may take the form of a telephone discussion. Both nurses must be named in the record of the review, and the record must show that the review was conducted by telephone.
- In the event that the Band 7 out-of-hours duty nurse is not available, the review must involve, as a minimum, telephone consultation with the Band 6 Bed Manager Clinical Lead (inpatient), available via switchboard, or another suitable nurse identified in consultation with the relevant SOM or the on-call manager.
- Both nurses must be named in the record of the review, and the record must show that the review was conducted by telephone. The nurse who is consulted (ie who is not present at the review) should make a brief note on the patient's Insight daily record of the discussion.
- Any nursing review involving only one registered nurse, or involving telephone consultation must be recorded on an incident report; one report may be submitted to report multiple reviews of a patient within one shift.

In the event that concerns regarding the patient's condition emerge during a nursing review, this should be immediately brought to the attention of the patient's responsible clinician or duty doctor

6.6.2 The Sleeping Patient

- If the patient in seclusion is asleep the need for review during the night (ie between 22.00hrs and 08.00hrs) should be discussed with the on-call doctor who would be responsible for undertaking the medical review and with the senior nurse on duty for the night shift
- If it is agreed that the medical and nursing reviews can be omitted if the patient remains asleep throughout the night, this decision should be recorded on the seclusion documentation
- Observations must be maintained as described above (6.3.3)
- If it appears on waking that seclusion may no longer be necessary, the need for

continuing seclusion should be reviewed within 30 minutes of waking

6.7 Medical Reviews - content

Medical reviews provide the opportunity to evaluate and amend seclusion care plans. They should be carried out in person and should include, as necessary:

- a review of the patient's physical and psychiatric health, including the possibility of hypoxia following restraint
- an assessment of adverse effects of medication
- a review of the observations required (with regard to the time interval requirements above at 6.3.3)
- 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 less restrictively.

6.8 Subsequent Reviews Schedule and Combined or Substituted/Replaced Reviews (see flow chart p4)

6.8.1 Medical Reviews - ongoing

- Four-hourly medical reviews should be carried out, including in the evenings, night time, on weekends and bank holidays, until the first Internal MDT review of seclusion has occurred
- **Office hours:** Four-hourly reviews to be conducted by any ward doctor or any available doctor
- **Outside office hours:** Four-hourly reviews to be conducted by the duty doctor
- If the patient is sleeping at night (22.00hrs-08.00hrs), the reviewing doctor and the Nurse in Charge may agree to omit or delay a review

Following the first internal MDT review (see 6.8.2), medical reviews should continue at least twice in every 24-hour period

- Twice-daily medical reviews do not need to be at 12-hour intervals, both may take place during office hours
- **Office hours:** At least one to be conducted by the RC or, exceptionally, by a senior doctor (Higher Trainee/SAS doctor)
- **Outside office hours:** At least one of the two reviews is to be conducted by a senior doctor (contact a higher trainee/SAS doctor in the first instance; if unavailable contact the on call consultant). This out of hours review will usually form the medical component of the MDT review (see below)
- The remaining medical review to be undertaken as for the 4-hourly reviews
- Where seclusion continues, the reviews should evaluate and make amendments, as appropriate, to the seclusion care plan

- **Combination:** A medical review can be combined with a nursing review (ie both are achieved by the nurse and the doctor being present together)

6.8.2 Internal MDT Reviews

- An internal review of seclusion is to be undertaken by the MDT as soon as practicable. This must be BEFORE 17.00 on the day following the commencement of seclusion, but NOT between 22.00hrs and 08.00hrs
- Internal MDT reviews continue thereafter on a daily basis
- **Definition of MDT - office hours:** RC (or a doctor who is an AC), or in exceptional cases, an SAS doctor or a Higher Trainee, plus the Senior Nurse on the ward, plus staff from other disciplines if available, plus, if possible, the patient's IMHA
- **Definition of MDT - outside office hours:** as a minimum - a senior doctor (contact a higher trainee/SAS doctor in the first instance; if unavailable contact the on call consultant) plus the senior nurse on the ward
- Where seclusion continues, the reviews should evaluate and make amendments, as appropriate, to the seclusion care plan
- **Inform the on-**call manager of the outcome of an MDT review undertaken outside office hours
- An internal MDT review may call for an Independent MDT review at any time

- **Combination:** An internal MDT review also achieves a medical review and a nursing review (ie all three are achieved because the internal MDT includes a doctor and a nurse), and
- **Substitution/Replacement:** There is no need for an outside office hours internal MDT review if there is to be an outside office hours independent MDT review (see below 6.8.3)

6.8.3 Independent MDT Reviews

If seclusion persists for 8 hours consecutively or 12 hours intermittently during a 48-hour period, an Independent MDT review is triggered

- The first independent MDT review is required as soon as is practicable BEFORE 17.00 on the day following the trigger, but NOT between 22.00hrs and 08.00hrs. The review is not required the moment it is triggered
- Each independent MDT review will schedule a further Independent MDT review within 7 days
- Each subsequent independent MDT review must take place during office hours
- Attendees should not have been involved in the incident leading to seclusion
- **Definition of Independent MDT - office hours:** a doctor who is an AC (or in exceptional cases an SAS doctor or a Higher Trainee) and senior nursing staff MUST attend, plus members of the wider MDT. The patient's IMHA (if s/he has one) should be invited.
- **Definition of Independent MDT - outside office hours:** as a minimum - a senior doctor (contact a higher trainee/SAS doctor in the first instance; if unavailable contact the on call consultant) plus the senior nurse on the ward.
- If it is agreed that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan

- As guidance, the independence of the reviewer is likely to be diminished after 2 consecutive reviews, however, in all circumstances, ensuring the reviews occur should take priority; reviews should not be delayed on account of repeated involvement of the same staff where this is unavoidable
- Where seclusion continues, the reviews should evaluate and make amendments, as appropriate, to the seclusion care plan
- The Clinical Director is to be informed if seclusion is not terminated, and of the date of the next scheduled Independent Review

- **Combination:** An Independent MDT review also achieves an Internal MDT review, a medical review and a nursing review (ie all four are achieved because the Independent MDT includes a doctor and a nurse), and
- **Substitution/Replacement:** An outside office hours independent MDT review replaces the outside office hours internal MDT review

6.9 Ending seclusion

- Seclusion should immediately end when a MDT review, a medical review or the independent MDT review determines it is no longer warranted.
- Seclusion cannot be ended by a nursing review. If the nursing review concludes that seclusion is no longer warranted, seclusion may end following consultation with the patient's responsible clinician or duty doctor
- This consultation may take place in person or by telephone.
- 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. (See Addendum to Seclusion Policy)
- Opening a door for toilet and food breaks or medical review does not constitute the end of a period of seclusion.
- At the end of each episode of seclusion the completed forms must be distributed as per the guidance on the seclusion forms

6.10 Flexible seclusion

Where there are periods of prolonged Seclusion it may be difficult to judge when the need for seclusion has ended. The Mental Health Act Code of Practice 2015 allows for a period of flexible seclusion to support teams to evaluate a patient's mood and degree of agitation under a lesser degree of restriction without terminating the seclusion episode.

Examples of flexible seclusion are:

- allowing patients to receive visitors
- allowing meals to be taken in the general area of the ward
- allowing access to secure outside areas (MHA Code of Practice, para 26.111).

6.11 Seclusion Care Plan

The individual should be helped and supported to re-integrate into the unit at the earliest safe opportunity.

The care plan should set out:

- A statement of clinical needs (including any physical or mental health problems),

risks and treatment objectives

- A plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed
- How any adverse effects of medication, physical restraint or illness are to be monitored and the action to be taken. The Early Warning Score tool in the Physical Health Policy supports such observations
- Details of bedding and clothing to be provided
- How the patient's dietary needs are to be provided for, for example, if the use of cutlery and breakable crockery is not to be permitted
- How hydration is to be maintained, including safe provision of hot drinks

  NB - A nursing record must be maintained of diet and fluid intake
- How toileting and hygiene needs are to be met

  - How access to fresh air might be achieved
  - How to make the patient aware of what they need to do for the seclusion to come to an end
  - Details of the support that will be provided when the seclusion comes to an end. Including a reintegration plan.
  - Details of any family or carer contact/communication which will maintained during the period of seclusion. Due regard must be given to the appropriateness of informing others of the seclusion. Consent will be required if the secluded person has capacity to decide

6.12 Rapid Tranquillisation and Seclusion

The Trust policy for rapid tranquillisation must be followed including the relevant record keeping.

The use of seclusion with rapid tranquillisation is not absolutely contraindicated. If used, the following advice should be followed:

- The patient should be monitored by an appropriate individual who is trained as a minimum in basic life support. Observing staff must be given clear information about what they are observing for and in what circumstances to seek immediate help.
- Once rapid tranquillisation has taken effect, the continued use of seclusion should be re-assessed taking into account the individual needs of the patient.

6.13 Rights of the Secluded Individual – MHA Code of Practice Chapter 26.45 – 26.

Any restrictive intervention must be compliant with the Human Rights Act 1998, which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR). (Mental Health Act Code of Practice 2015 ch 26.45)

No restrictive intervention should be used unless it is medically necessary to do so in all circumstances of the case. Action that is not medically necessary may well breach a patient's rights under ECHR Article 3, which prohibits inhuman or degrading treatment (Mental Health Act Code of Practice 2015 ch 26.47).

For this reason, it is essential that the rationale for using seclusion is fully recorded.

Services and their staff should help all patients to understand the legal authority for any proposed action and their rights. (Mental Health Act Code of Practice 2015 ch 26.46).

Some individuals may wish to make a formal complaint or compliment about their care or treatment; they should be made aware of the 'Fast-track' process and offered any support necessary to complete the documentation (e.g. from Advocacy services).

6.14 Guidance in Response to Fire

- If there is an intermittent alarm, seclusion should be maintained with staff immediately ready to unlock the door
- The patient should be informed that evacuation is not currently necessary, but will become so if the alarm sound changes from intermittent to continuous
- Should it be necessary to evacuate the ward, efforts should be made to transfer the patient to the Seclusion room on the neighbouring Ward. This should be supported by staff providing assistance from the neighbouring Ward
- If it is not possible, to transfer seclusion to a neighbouring ward, the secluded patient should be evacuated alongside other patients,
- Once evacuated, reasonable efforts should be made to supervise the previously secluded patient. It is recognised that the ability to do this may be affected due to the presenting circumstances
- In such circumstances, staff are guided to focus on the safety and wellbeing of the majority of patients/patients and of the staff team.

6.15 Entering the Seclusion Room

If the nursing team and/or MDT wish to enter the seclusion room in order to engage with the secluded person or to provide care, then the seclusion room should not be entered without prior planning for the safety of all concerned.

- Due regard should be given to the purpose of entering, whether this is strictly necessary relative to the assessed risk, and how entry and exit should be effected.
- A team comprising at least three Level 3 RESPECT trained members of staff should be present when it is necessary to enter the room
- Staff must assess the secluded individual's ability to maintain themselves safely; this can be achieved by asking that the individual comply with a request to sit on the mattress
- If the individual is too disturbed or distressed to comply with such a request, entering the seclusion room, if found to be necessary, must carefully planned
- Persons other than members of the MDT may enter the seclusion room if necessary, subject to risk assessment. These individuals must be informed of any risks and the associated management plans
- The seclusion record must note all occasions when the room was entered, including who entered and the reasons for doing so

6.16 Seclusion room when not in use

- The seclusion room should be kept locked when not in use
- Following every episode of seclusion, the nurse in charge must ensure that the seclusion room is thoroughly cleaned
- Once the room has been cleaned, the nurse in charge is responsible for ensuring the seclusion room is checked for safety, integrity and for the presence of any untoward items/ implements, and then re-locked

6.17 Service User Post Incident Reviews Following Seclusion:

Following a period of seclusion the individual must be given the opportunity to participate in a discussion about the incident; this is a post incident review. There is a 'Service User Post-Incident Review form on Insight in the drop-down box 'add new'.
As part of this discussion the clinical rationale for seclusion should be explored with the patient and they should be supported in the process of re-integration to normal ward activities.

Nursing time should be set aside to facilitate this process. Following a period of seclusion it is essential that the nursing staff re-establish the therapeutic relationship with the previously secluded patient. Elements of this discussion will include:

- Does the individual understand why they were secluded?
- Does the individual agree that seclusion was necessary?
- Does the individual accept that the action taken was reasonable and appropriate?
- How does the individual feel now, after the event?
- How can we avoid the need for any further episodes of seclusion in the future?

The post incident review should be offered within 72 hours of an incident ending.

The outcome should be recorded on the Post Incident Review form and forwarded with the seclusion record to the Manager of the service. It is good practice to follow up this internal review with a review conducted by a staff member who does not work with that team and a patient who is not currently being cared for by that team. Support with this process can be accessed through the Patient Monitoring Unit (S.U.M.E.U.) which is based at Fulwood House.

All data on seclusion will be collated by the appropriate Manager for reporting along with other data on violence/aggression to the Senior Management Team. RESPECT leads will collate data for peer review purposes through the Restrictive Interventions Reduction Programme.

6.18 Emergency Equipment

Refer to the SHSC Resuscitation policy for guidance. It is the duty of all staff to ensure that they know where the emergency equipment is stored in the clinical area within which they are working.

6.19 Delivering Equality

People using the service will come from diverse backgrounds and there will be many differences in relation to:

- Age
- Class
- Disability
- Ethnicity
- Gender
- Religion and beliefs
- Sexual orientation

The cultural needs of people whilst in seclusion need to be addressed, balancing the need for staff to carry out rigorous risk assessments against an individual's rights in respect of their beliefs, eg the removal of an article used for religious practice which may, in the context of seclusion, cause risk to themselves or others.

Additionally, members of staff need to carry out a similar rigorous risk assessment with regard to disability aids before these are removed, eg spectacles and walking frames. A balance needs to be found between the risk these items may pose to the patient and/or care staff, and the role of these items in promoting the independence of the patient.

When staff are communicating with individuals from diverse communities the information provided should be in a form that is accessible to people with additional needs, for example, people with physical, cognitive or sensory impairment and people who do not speak or understand English.

Information should be provided in a way that is suited to the individual's requirements and enables them to understand what is happening and maintain communication with members of staff.

7 Dissemination, Storage and Archiving

A copy of this policy will be placed on the SHSC Intranet within 7 days of ratification and the previous version will be removed by the Communications team. This will be publicised via an 'all staff' e mail sent to SHSC staff, and in 'Connect'.

Managers are responsible for ensuring hard copies of previous versions of the Seclusion policy and the Seclusion pack are removed from affected areas.

8 Training and other resource implications

When considering training for a specific clinical area, a risk assessment should be carried out to ascertain the level of training suitable to that area, relevant to the prevalent risks and responsibilities of staff in the area in question. This should be done by the SOM and Ward Manager. Along with the RESPECT lead professional.

- All staff who will be involved in clinical care of patients will receive RESPECT Training as appropriate to their level of patient contact

- All staff trained in RESPECT are also to be trained annually in Basic Life Support.

- All registered nursing staff are to be trained in or Immediate Life Support and to be up to date in this training

- The identification of individual staff training needs is the responsibility of line managers and the RESPECT lead professional, in line with the SHSC training needs analysis

9 Audit monitoring and review

Monitoring Compliance Template						
Minimum Requiremen	Process for Monitoring	Responsible Individual/ group/ commi tee	Frequency of Monitoring	Review of process (e g. who does this?)	Responsible Individual/ group/ committee for action plan development	Responsible Individual/ group/ committee for action plan monitoring and implement-ation
Adherence to policy require-ments	Review by Restrictive Inter-ventions Group	Restrictive Inter-ventions Group	Each meeting	Restrictive Inter-ventions Group	Restrictive Inter-ventions Group	Restrictive Inter-ventions Group

10. Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
Upload the revised policy onto intranet and Trust website and remove/ archive the old version.	Head of Communications	Within 5 working days of ratification	
Issue a communication to front line staff and managers.	Head of Communications	Within 5 working days of ratification	

11. Links to other policies, standards and legislation (associated documents)

Aggression and Violence: Respectful Response and Reduction Policy
Education, Training and Development Policy
Good Practice Guidelines on the Prevention and Management of the Use of Restraint
Guidelines for Advance Statements
Incident Reporting and Investigation Policy
Interpreting and Translation Policy
Medicines Management Policy
Observation of Inpatients Policy
Personal Search Policy
Physical Health Care Policy
Rapid Tranquillisation Policy
Records Management Policy
Resuscitation Policy

12. Contact details

Title	Name	Phone	Email
Clinical Nurse Manager	Kim Parker	63306	kim.parker@shsc.nhs.uk
Head of mental Health Legislation	Anne Cook	64913	anne.cook@shsc.nhs.uk

13. References

- Human Rights Act 1998;
- Mental Health Act 1983;
- Mental Health Act Code of Practice 2015
- The NICE guidance 'Violence and aggression: short-term management in mental health, health and community settings' (2015)
- NICE Guideline 25.
- NICE Guideline 136.
- Prevention and Management of the use of Restraint: Framework for Good Practice - Sheffield City Council and NHS Sheffield.
- Positive and Proactive Care: Reducing the need for restrictive interventions, DoH, (2014)
- SHSC Guidelines for Use of Green Rooms.

Appendix A - Version Control/Review and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
4.0	Review / ratification / issue	Nov 2016	Policy reviewed to reflect changes brought about by the updated Code of Practice to the Mental health Act 1983
5.0	Amendment	March 2017	Amended to remedy an omission from previous content with regard to Independent MDT Review of Seclusion. In order to conform to the Policy for Policies, a table and a flow chart were removed from the body of the document and cross-referenced to Appendix G. The content of paragraphs 6.4.1 and 6.4.2 has been reversed to facilitate cross-reference to Appendix G.
6	Review	May 2018	Policy reviewed to: remove some unnecessary content update references clarify the review of seclusion schedule clarify which staff are authorised to carry out reviews identify which reviews can substitute for other reviews include a contingency for nursing reviews when only one nurse is present Remove seclusion pack Remove redundant appendices. Use the term ‘patient’ in keeping with the MHA Code of Practice, which is the source of the policy

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
4.0	Nov 2016	Nov 2016 – via Communications Gazette	
5.0	May 2017	via Communications Gazette	
6.0	June 2018	Via Connect and all staff e mail	

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	**No**		
DISABILITY	**No**		
GENDER REASSIGNMENT	**No**		
PREGNANCY AND MATERNITY	**No**		
RACE	**No**		
RELIGION OR BELIEF	**No**		
SEX	**No**		
SEXUAL ORIENTATION	**No**		

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date) Anne Cook 19.05.2018

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

☐ ✓ **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. On completion of flow diagram – is further action needed?

☐ **No, no further action needed.**

☐ **Yes, go to question 3**

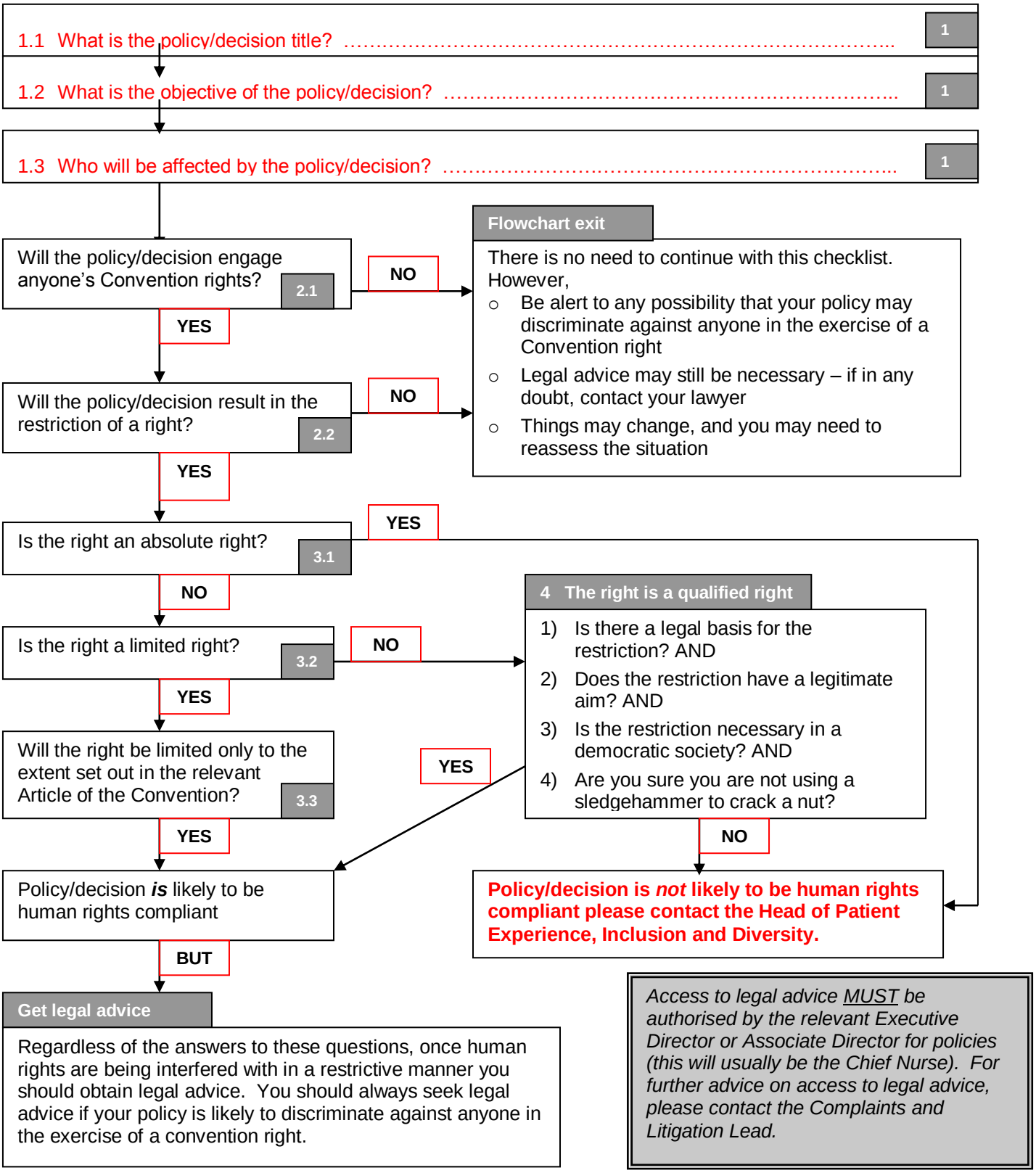
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix E – Development, Consultation and Verification

This policy has been developed over time in line with changes to the Mental Health Code of Practice (previously on the 2008, now reflecting the current document published in 2015). The Mental health Act Committee undertook the initial review of the policy on publication of the 2015 Code of Practice, in consultation with Ward Managers and Staff, senior nursing and medical staff, and Clinical and Service Directors. These staff groups have also been consulted for the current version

The changes listed in Appendix A were influenced by feedback from these groups and individuals

The Restrictive Interventions Group verified this version of the document; consultation occurred between October 2017 and May 2018

This is Version 6 of this policy, replacing Version 5 which was issued in May 2017.

Appendix F –Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy template which can be downloaded on the intranet (also shown at Appendix G within the Policy).

1. Cover sheet ☐

All policies must have a cover sheet which includes:

- The Trust name and logo √
- The title of the policy (in large font size as detailed in the template) √
- Executive or Associate Director lead for the policy √
- The policy author and lead √
- The implementation lead (to receive feedback on the implementation) √
- Date of initial draft policy √
- Date of consultation √
- Date of verification √
- Date of ratification √
- Date of issue √
- Ratifying body √
- Date for review √
- Target audience √
- Document type √
- Document status √
- Keywords √
- Policy version and advice on availability and storage √

2. Contents page

3. Flowchart √

4. Introduction √

5. Scope √

6. Definitions √

7. Purpose √

8. Duties √

9. Process √

10. Dissemination, storage and archiving (control) √

11. Training and other resource implications √

12. Audit, monitoring and review √

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

13. Implementation plan	√
14. Links to other policies (associated documents)	√
15. Contact details	√
16. References	√
17. Version control and amendment log (Appendix A)	√
18. Dissemination Record (Appendix B)	√
19. Equality Impact Assessment Form (Appendix C)	√
20. Human Rights Act Assessment Checklist (Appendix D)	√
21. Policy development and consultation process (Appendix E)	√
22. Policy Checklist (Appendix F)	√

Appendix G - Long-term Segregation

Please refer to Mental Health Act Code of Practice 2015 Chapter 26: 150- 160.

1. Long-term segregation (LTS) 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 multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. 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.

2. In order for LTS to be permissible, the clinical judgement is that, if the patient were 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. Where consideration is being given to long-term segregation, wherever appropriate, the views of the person's family and carers should be elicited and taken into account. The multi-disciplinary review should include an IMHA in cases where a patient has one.

3. It is permissible to manage this small number of patients by ensuring that their contact with the general ward population is limited. The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow.

4. Facilities which are used to accommodate patients in conditions of LTS should be configured to allow the patient to access a number of areas including, as a minimum:

    - bathroom facilities,
    - a bedroom
    - a relaxing lounge area
    - access secure outdoor areas
    - access to a range activities of interest and relevance to the person

5. Patients should not be isolated from contact with staff (indeed it is highly likely they should be supported through enhanced observation) or deprived of access to therapeutic interventions.

6. The patient's treatment plan should clearly state the reasons why LTS is required. In these cases, the way that the patient's situation is reviewed needs to reflect the specific nature of their management plan.

7. The purpose of a review is to determine whether the on-going 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.

8. 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.

9. At times of acute behavioural disturbance where there is a need to contain an immediate risk of harm to others, there may be a need to transfer the person to a physical area that is more secure and restrictive and has been designed for the purpose of seclusion. In such a situation, the policy for seclusion must be followed.

Checklist 1: Authorising Long-term Segregation

If the answer to any of these questions is 'no' long-term segregation **must not** take place.

Condition to be satisfied	Y or N
The minimum facilities, described at paragraph 4, are immediately available to the patient	
The patient poses a risk of harm (physical or psychological) to others as a **constant feature of their presentation**	
The patient's record includes clear documented evidence of the risk to others, including its nature and frequency	
The patient's record includes clear documented evidence detailing why a less restrictive approach is not possible- i.e. specific reasons why shorter-term seclusion would not suffice, and the rationale for rejecting any other treatment measures.	
The LTS is agreed to be necessary by the MDT and the discussion is documented in the patient's record. The MDT should comprise as a **minimum** the patient's **RC, the Ward Manager and the Clinical Director or Associate Clinical Director**. Staff from other disciplines may be involved if available, and the patient's IMHA should be involved if possible.	
The LTS is agreed by **a representative of the Commissioning Body.** **Name of person notified ……..** **Date above named agreed LTS…….** It is the responsibility of the RC or Ward manager to notify the commissioning body	
There is a care plan in place with the aim of ending LTS, detailing the staff support that will be provided in order to reduce the specific risk to others which warrants the period of the LTS	

Checklist 2: Monitoring and Reviewing Long-term Segregation

All elements of the checklist must be completed as they occur.

Condition to be satisfied	Y or N
The **Local Safeguarding Team** has been notified of the LTS. **Name of person notified ……..** **Date of Notification ……**	
The patient's family or other carer/friend has been notified of the LTS and their views taken into account (give due regard for patient confidentiality and ability to consent to disclosure)	
The patient's care plan should detail how the patient is to be made aware of what is required of them so that the period of long-term segregation can be brought to an end.	
The patient's record is updated on an hourly basis and reflects the presence or absence of the behaviours which warrant the period of LTS	
The following schedule for review is clear in the care plan **Daily:** 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 **Weekly (minimum)** The patient's situation should be formally reviewed by the full MDT. **As necessary –** Is there any aspect of the plan that would warrant a more frequent review **Monthly -** review by a senior professional who is not involved with the case. This should be an **AC or Senior Nurse (Band 8a or above)** **3-Monthly -** Where long-term segregation continues for three months or longer, **regular three monthly** reviews of the patient's circumstances and care should be undertaken by an **external hospital.** This should include discussion with the patient's IMHA (where appropriate) and commissioner.	
Where successive weekly MDT reviews determine that LTS should continue, there is documented evidence of the reasons why the patient **cannot be supported in a less restrictive manner.**	
The outcome of all reviews and the reasons for continued segregation has been recorded and the responsible commissioning authority should be informed of the outcome).	