Sheffield Health and Social Care NHS Foundation Trust

Policy:

NPCS 009 SECLUSION AND SEGREGATION POLICY (INC LONG TERM)

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Summary of policy

This policy and procedure provide clear guidance on the use of seclusion and long-term segregation within SHSC - NHS Foundation Trust.

It allows the Trust to demonstrate that the use of restrictive practices meet and uphold the guiding principles of the Mental Health Act Code of Practice (2015), Use of Force Act, 2018 and the Human Rights Act 1998, and that they remain proportionate, least restrictive, last for no longer than is necessary, and take account of patient preference wherever possible.

Target audience	All SHSC staff (including those who are seconded into or working in SHSC services) working in settings where seclusion or segregation may be used

Keywords	Least restrictive, proportionate, human rights, seclusion, observations, review, record keeping, long term segregation, careplanning, service user involvement, advocacy, incident reporting, Directorate Leadership Team

Storage & Version Control
Version 9 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (V8 August 2021). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
0.1	New draft policy created	MM/YYYY	Revision of policy commissioned by PGG.
1.0	Approval and issue	MM/YYYY	Amendments made during consultation, prior to ratification.
2.0	Review / approve / issue	MM/YYYY	
2.1	Review on expiry of policy	MM/YYYY	Committee structure updated
3.0	Review / approval / issue	MM/YYYY	Full review completed as per schedule
7.0	Review / approval / issue	08/2021	Full review completed as per schedule
8.0	Review/approval/issue	01/2022	Further review and consultation completed
9.0	Review/approval/issue	03/2022	Further review and consultation completed
9.1	Review/approval/issue	09/2022	Interim review undertaken and submitted 28/09/2022 Changes specific to term “triumvirate” changed to Directorate Leadership Team and to prolonged review section

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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 is authorised by a psychiatrist.
If this psychiatrist is not the patient's RC, the RC or, if out of hours, the duty doctor **should** be informed of seclusion as soon as practicable.
Medical review within one hour not required
4-HOURLY MEDICAL REVIEWS COMMENCE
If the patient has been subjected to any restrictive intervention prior to seclusion, there should be an immediate medical review (risk of hypoxia)

Seclusion is authorised by the nurse in charge of the ward.
The patient's RC or, if out of hours, duty doctor (or equivalent) **must** be informed of seclusion as soon as practicable.
MEDICAL REVIEW REQUIRED WITHIN 1 HOUR or WITHOUT **DELAY** if the individual is not known or there is a significant change from their usual presentation.
If the patient has been subject to restrictive intervention prior to seclusion, there should be an immediate medical review (risk of hypoxia)

Proceed to seclusion room.
RESPECT trained staff should employ approved techniques if restraint is required. Seek attendance of RESPECT trained staff from other wards if necessary and feasible.

Search Patient using RESPECT techniques.
Remove items for safekeeping. Record items removed and store safely

Seclusion **should** only be utilised for detained patients.
If patient is not detained and seclusion is necessary to prevent harm to others, an application for detention under the MHA should be instigated **IMMEDIATELY**

Nurse in Charge arranges for Seclusion reviews to commence – see schedule below

Nurse in Charge arranges for:
observations of patient and recording to commence; physical healthcare monitoring and recording to commence; relative/carer to be informed if agreed and appropriate (consider patient consent); completion of incident form (seclusion is a moderate reportable incident) on-call manager to be informed if necessary

Seclusion Care Plan
If seclusion continues after the first medical review a seclusion care plan should be agreed and prepared. This will identify how the patient's presenting and on-going needs whilst in seclusion can continue to be met and will detail what the patient is able to have access to in the seclusion room and what is important to them during this time.

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.

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

Medical Reviews continue 4-hourly until the first Internal MDT Review and decision to maintain at 4 hourly or reduce to twice within 24 hours

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

MDT review to agree on review schedule, whether to continue 4 hourly reviews or reduce to twice within 24 hours

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 flow co-ordinator 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: If Medical Reviews are reduced 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

Sheffield Health and Social Care NHS Trust is committed to establishing a culture on its wards which focuses on early recognition, prevention and de-escalation of potential aggression using techniques that minimise the risk of its occurrence. It is committed to the provision of strategies and alternatives, through a skilled and knowledgeable workforce and environment, that seek to de-escalate situations to prevent the use of seclusion and segregation.

There may be times when an individual using Trust services and detained under the Mental Health Act may need to be moved from the communal ward environment and placed in seclusion or segregation away from others for the safety of themselves or others. This policy explains how such seclusion and segregation should take place within the Trust to maintain the safety, dignity, and care of those subject to these restrictions, maintains human rights, trauma informed care and ensures that practice is in line with legislation and the Code of Practice.

This policy takes into account the requirements of the Human Rights Act 1998, the Mental Capacity Act 2005, Mental Health Act 1983 (as amended 2007), The Mental Health Act Code of Practice (2015), Use of Force Act (2018) and relevant NICE guidelines.
Its links directly to the Trust policy on Use of Force (December 2021)

1.1 Sheffield Health and Social Care NHS Foundation Trust incorporates a range of low secure, intensive rehabilitation and psychiatric intensive care mental health services, in addition to a range of adult, older peoples and learning disability services.

1.2 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)). Consequently, in relation to seclusion and segregation, departure from the Code is only authorised under exceptional, justifiable circumstances, and only where there are cogent reasons for doing so. The statutory scheme, while providing for the Secretary of State to give guidance, deliberately left the power and responsibility of final decision-making to those who bear the legal and practical responsibility for detaining, treating, nursing and caring for the patients. The Trust's policy defines a procedure for seclusion and segregation which does not permit arbitrary or random decision-making and, furthermore, ensures that the rules are accessible, foreseeable and predictable.

1.3 The Trust recognises the importance of the Code and has incorporated its principles into this policy. It is the responsibility of all members of the Patient Care Team and their managers to ensure that seclusion and segregation is used as described within this policy. They are also responsible for ensuring that they record, monitor and

review their use of seclusion and segregation and collaborate with the managerial arrangements for monitoring these within their services.

1.4 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.

1.5 It is recognised that different areas of the Trust use differing terminology when it comes to patients/service users. For the purpose of this policy the term 'patient' has been used for no other reason that this is the term used within the Mental Health Act (1983) and throughout the Code of Practice (2015).

2 SCOPE

This policy applies to all staff employed in Sheffield Health and Social Care NHS Foundation Trust, including bank workforce staff and any other staff seconded into or working in SHSC services.

3 PURPOSE, AIMS and OBJECTIVES

The overall aim of the Trust is to prevent the use of seclusion and segregation by the establishment of a culture focussing on the early recognition, prevention, and de-escalation of potential aggression, using techniques, strategies and alternatives that minimise the risk of its occurrence.

Where seclusion and segregation are used the aim is: -

3.1 To provide clear guidance on the use of seclusion and segregation.

3.2 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].

3.3 To ensure inpatient areas have robust and transparent governance processes that support, monitor, advise and report on the use of the restrictive practices of seclusion and segregation.

3.4 To meet and uphold the guiding principles of the Mental Health Act Code of Practice as highlighted in Chapter 26.110. These are to:

- 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 or segregation 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 segregation and any follow-up action

3.5 To support the Trust's commitment to the least restrictive practice and safe and positive care for all patients.

4 DEFINITIONS

4.1 **Seclusion** in this policy is as defined in Chapter 26.103 of the Code of Practice and is held to be:

"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"

4.2 The Trust also notes Chapter 26.104 of the Code of Practice which states that:

"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 the conditions of the immediate environment do not change the fact that the patient has been secluded".

4.3 **Long-Term segregation (LTS)** in this policy is as defined in Chapter 26.150 of the Code of Practice and is held to be where:

"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. The clinical judgment 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"

SHSC will ensure that any use of **segregation** is recorded, monitored and safeguarded aligned to the definition of Long-Term Segregation, as indicated in the CQC report "Out of Sight" 2020.

De-Escalation	• Patient is escorted without restraint to a room which is separate from other patients. • Staff remain and work with the patient to gradually resolve the potentially violent or aggressive situation. • If successful, the patient calms and is free to leave the room. • It is a gradual process, for which it may be difficult to set time limits. • **Seclusion procedures do not apply.**
De-escalation whilst restrained	• Patient is escorted whilst physically restrained to a room which is separate from other patients. • Staff remain and work with the patient to gradually resolve the potentially violent or aggressive situation. • If successful, the patient calms, restraint is stopped and the patient is free to leave the room. • It is a gradual process, for which it may be difficult to set time limits. • **Seclusion procedures do not apply.**
Seclusion	• Patient is placed on their own in a locked room, usually this involves physical restraint. • The patient is not free to leave. • Staff physically prevent the patient from leaving – this may be by a locked door or a door held closed or by staff standing to bar the patient's exit. • At the point that the patient is compelled to stay in the room, seclusion is initiated, and **seclusion rules apply.**
De-escalation that becomes Seclusion	• Patient is escorted to a room which is separate from other patients whilst physically restrained. • Staff stay and work with the patient to gradually resolve the potentially violent or aggressive situation. • The patient does calm and restraint is stopped but the patient is told that they cannot yet leave the room and must stay there, either with or without staff remaining in the room. • At the point that restraint is stopped but the patient is compelled to stay in the room, seclusion is initiated, and **seclusion rules apply.**
Segregation	• In order to manage a sustained risk of harm, the MDT meet and agree that a patient should not be allowed to mix freely with other patients on the ward for a long-term basis. • The patient is compelled to stay in an area for all or the majority of the day. • It has been approved by the appropriate triumvirate and validated with the Executive Clinical Leads and Responsible person for the Use of Force. • In this area, the patient has access to a bedroom, lounge, bathroom facilities and therapeutic activities. • **Long term segregation rules and reviews apply**

4.4 **Other Definitions**

Advance 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. Advance statements are not legally binding although health professionals should take them into account when making decisions about care and treatment.

Independent review – a review conducted by staff or appropriate individual(s) not directly involved in the patient's care planning or in the initial decision to implement the seclusion/ long-term segregation.

Approved Clinician (AC) – a person approved by the appropriate national authority to act as an approved clinician for the purposes of the Mental Health Act 1983 (as amended 2007).

Responsible Clinician (RC) – the Approved Clinician who has been given overall responsibility for a patient's case.

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 nurse of Band 7 or above.

Independent Mental Health Advocate – an advocate available to offer help to patients under arrangements which are specifically required to be made under the Act.

Multi-disciplinary team – a professional team including staff from a range of different professions.

Clinical Directorate Leadership team – consists of the Head of Nursing, Head of Service, Clinical Director and Senior Matron who role is to have responsibility and authority to ensure implementation and assure adherence to trust policies and procedures through the management structure with the purpose of oversight, support and assurance.

De-escalation techniques – a set of non-physical interventions intended to reduce a person's heightened state of arousal and the risk of harm to self, others and the environment. See Use of Force Policy (December 2021)

De-escalation room/Green Room/Relaxation Room – low stimulus environment which the patient can use or choose to go into and can leave at any time.

Positive Behavioural Support Plans – individualised care plans, which should be available to staff, kept up-to-date, and should include primary preventative strategies, secondary preventative strategies and tertiary strategies.

Restrictive Intervention – are deliberate acts on the part of other persons that restrict a person's movement, liberty and/or freedom in order to take immediate

control of a dangerous situation where there is real possibility of harm to the person or others and to end or reduce significantly the danger to the patient or others.

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

Electronic Care Record – database in which section details, progress notes, risk assessments and recovery plans are recorded for each person that uses Trust services.

Ulysses – the Trust's Risk Management System (RMS). An online incident reporting system that allows staff to record incidents for immediate action and later learning.

PRN Medication – pro re nata -'when needed'. In this policy PRN refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or harm.

Rapid tranquilisation – use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation medication is required.

5 DETAILS

This policy explains how seclusion and segregation should take place within the Trust to maintain the safety, dignity, and care of those subject to these restrictions, maintains human rights, trauma informed care and ensures that practice is in line with legislation and the Code of Practice.

6 DUTIES and RESPONSIBILITIES

In line with the Use of Force Act (2018) – Statutory guidance - each Mental Health Unit or Group of Mental Health Units must identify a **Responsible Person**. This is the Director of Quality for SHSC. The duties for this role include:

- Ensuring a policy is published regarding the Use of Force
- Ensuring information is published for patients about their rights in relation to the use of force.
- Staff receive appropriate training in the use of force
- Records are kept which include protected equality characteristics
- Statistics are published
- Investigations are undertaken where necessary to ensure learning.

The Chief Executive – is responsible for ensuring that systems on which the Board relies to govern the organisations are effective. The

statement of Internal Control is signed annually indicating that systems of governance, including risk management are properly controlled.

6.1.1 **Board of Directors** - are responsible for ensuring that a policy is in place that governs the safe and appropriate use of seclusion and long-term segregation via its governance arrangements and that all staff working in the trust are aware of and operate within the policy.

6.1.2 **Medical Director** - is responsible for ensuring that all medical staff are aware of and operate within the policy and procedure for the use of seclusion and long-term segregation. They also have the responsibility to oversee any appeals in relation to seclusion. They are the responsible person aligned to the Use of Force Act (see Director of Quality for nominated person)

6.1.3 **Executive Director of Nursing, Professions and Operations**: Is responsible for ensuring mechanisms are put in place to ensure nursing and allied health professionals within the services are aware of and comply with the requirements of the policy and procedure for the use of seclusion and segregation.

6.1.5 **Director of Quality**: Is the nominated Responsible Person on behalf of the Medical Director who oversees the implementation of the Use of Force Act (2018). All use of seclusion and segregation must be notified via incident reporting to the Director of Quality; all MDT discussions about the proposal to implement segregation must involve the Director of Quality and the Medical Director.

6.1.6 **Director of Operations**. The Director of Operations is responsible for ensuring that all managed staff members are aware of and operate within the policy and procedure for the use of seclusion and long-term segregation, whilst also ensuring that staff members attend any mandatory training and that there is appropriate performance monitoring.

6.1.7 **Clinical Directors and Heads of Nursing.** Have the responsibility to maintain oversight of the use of seclusion and segregation within their Directorate and attend the Least Restrictive Practice Groups.

6.1.8 **Responsible Clinicians**. It is the requirement that every patient who receives care from Sheffield Health and Social Care has a responsible clinician. With this accountability comes the overall care, treatment and monitoring delivered to patients nursed in seclusion or long-term segregation.

6.1.9 **Matrons/Team leads and Ward Managers.** Matrons have the responsibility for monitoring the adherence to the policy and procedure for the use of seclusion and segregation within their service on a daily basis. There is responsibility for ensuring that any appropriate training associated with the use of seclusion and segregation within the Trust is undertaken by staff within their service. In addition, they must ensure that:

- the use and monitoring of any seclusion and segregation complies with recommendations and control measures set out by the Trust
- they communicate any measures clearly to employees and to ensure they receive appropriate essential training
- all patient safety incidents are reported via the Trust incident reporting system
- they receive and monitor reports of seclusion and segregation incidents or potential incidents to ensure that data is complete and correct action is taken to prevent a recurrence
- they review incidents to identify situations where employees may be exposed to foreseeable risks such as verbal abuse, physical assault or a work-related safety hazard, and
- risk assessments are undertaken, implemented and documented.
- reviewing and maintaining their effectiveness at intervals not exceeding one year, when a significant change in circumstances occurs, or following any incident.
- Audits are completed are per Trust direction and any results from these audits are shared and acted upon.

6.1.10 **Multi-Disciplinary Teams**. It is an essential duty of the multi-disciplinary team that the use of seclusion and segregation within their areas of responsibility is managed in accordance with this policy and procedure, and that they participate fully in the monitoring and review arrangements contained within it. They are required to ensure that criteria for ongoing seclusion or segregation is being met and if not act accordingly to end seclusion. The MDT must work within the principles of the Act ensuring seclusion or segregation is the Least restrictive.

6.1.11 **Nurse in Charge of the Ward**. The nurse in charge of the ward is responsible for managing any incident of seclusion or segregation in accordance with this policy and procedure.

6.1.12 **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)

6.1.13 **Other Doctors.** The Trust has determined that all medical doctors, irrespective of grade, or level of registration will be considered competent to authorise seclusion and 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
- 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

6.1.14 **All staff**. All staff within the Trust with front-line exposure to patients have a responsibility to provide care in accordance with this policy and procedure.

6.1.15 **RESPECT team** - will provide and deliver appropriate training, with support of the training department, in line with the requirements of the standard NHSEI contract aligned to the Restraint Reduction Network Standards (2018). Levels of training will be identified via the training needs analysis and approved by the Least Restrictive Practice Oversight Group and Responsible Person for Use of Force Act (2018)

7 PROCEDURE - SECLUSION

7.1 General Principles of Seclusion

7.1.1 The Mental Health Act Code of Practice, 26.103 defines 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'.

7.1.2 If a patient is confined in any way which meets this definition, '…even if they have agreed to or requested such confinement…' the patient has been secluded and must be afforded the procedural safeguards of the Code. The use of local or alternative terms, such as therapeutic isolation, or the conditions of the immediate environment do not change the fact that the patient is secluded (Mental Health Act Code of Practice, 26.104).

7.1.3 All instances of care or intervention, e.g. transfer to De-escalation, 'Therapeutic Isolation', or 'time out' that meet the definition of seclusion must be treated as seclusion and the required reviews put in place.

7.2 When Seclusion Can Be Used

7.2.1 Seclusion may only be used for the containment of severe behavioural disturbance that is likely to cause harm to others. It may not be used solely as a means of managing self-harming behaviour (Mental Health Act Code of Practice, 26.108). When a patient poses a risk of self-harm as well as harm to others, seclusion should only be used 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.

7.2.2 Seclusion should not be used as a punishment or a threat, or because of shortage of staff. It must never form part of a treatment programme (Mental Health Act Code of Practice, 26.107) and as such cannot be planned or predicted to continue outside of the review schedule.

7.2.3 As seclusion may only be used to contain the severe behavioural disturbance that may cause harm to others, it is the responsibility to staff to assess the risk that a patient poses to others due to their challenging behaviour. In placing a patient in seclusion, staff must be able to demonstrate the decision-making which evidences that seclusion was used to:

- manage severe behavioural disturbance, which is likely to cause harm to others, and
- as a measure of last resort.

7.2.4 Seclusion should only be used in hospitals and 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 (Mental Health Act Code of Practice, 26.106).

7.2.5 It should be clearly recorded in the clinical notes and on the incident form whether the patient has been locked alone in a room or has been compelled to stay in a room with staff present.

7.3 Seclusion and Advance Decisions/Positive Behaviour Support Plans

7.3.1 All patients who may be at risk of engaging in severe behavioural disturbance likely to cause harm to others should have a Care Plan/Positive Behaviour Support Plan. Input should be sought from the patient in developing this plan and, where appropriate, from family members and carers. This plan should be clearly titled and should describe the interventions that effectively manage incidents of severe behavioural disturbance for that patient.

7.3.2 Where it has been agreed in a Care Plan/Positive Behaviour Support Plan with the patient that family members/carers/IMHAs will be notified of significant behavioural disturbances and the use of restrictive interventions, this should be done as agreed in the plan.

7.3.3 A well-drafted Care Plan/Positive Behaviour Support Plan focused on understanding the patient's behaviour in the context of their needs may help to minimise the use of seclusion.

7.4 Requirements of seclusion

7.4.1 The Code of Practice requires providers to have procedures which provide clear written guidance on "how restrictive interventions which are used should be authorised, initiated, applied, reviewed and discontinued, as well as how the patient should be supported throughout the duration of the application of the restrictive intervention" [Chapter 26.7]

7.4.2 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 [Chapter 26.64]

7.4.3 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 [Chapter 26.111]

7.4.4 Seclusion should be used as a last resort and for the shortest length of time possible

7.4.5 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 [Chapter26.107]. It cannot be prescribed or predicted outside of the review schedule.

7.4.6 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. [Chapter 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

7.4.7 The Trust will ensure that designated seclusion rooms meet the criteria identified within the Code [Chapter 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- to be risk assessed on commencement of seclusion and outcome recorded and communicated with staff and patient
- Where access to the ensuite, beds or necessary items is of concern any removal or prevention of this must be risk assessed and documented with a plan to review at each review point to consider introduction of access
- Using a floor mattress or restricting access to the ensuite must be incident reported

7.4.8 Seclusion should never be used solely as a means of managing self-harming behaviour. [Chapter 26.108] (See section 6.9)

7.4.9 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”. [Chapter 26.106]

7.4.10 Bedrooms should not be used for the purposes of seclusion, however in the event of an emergency and acute behavioural disturbance the decision to use a patient’s bedroom or other safe space for the purpose of seclusion may be required based on clinical rationale. Bedrooms will not meet the requirements of the seclusion environment as laid out by the Code of Practice. Where use of a bedroom or other space is deemed clinically necessary and no other alternatives identified, the matron (or out of hours manager) should be notified immediately, and an incident form completed to reflect the rational for this. A thorough risk assessment of the environment must take place, identifying safety issues and a plan to address. A post incident review must include reflection on the clinical justification for use of a non-approved seclusion room.

7.4.11 En-suite facilities (where available) should be routinely accessible by the patient in seclusion unless, following risk assessment, there are specific concerns raised about potential self-harm or risk to others. This risk assessment should occur at the commencement of seclusion and be reviewed at every review point particularly if access is restricted.

7.4.12 Whilst in seclusion, the patient will be

- Advised of the reasons for being placed in seclusion. This should be repeated at subsequent reviews if required
- Advised under what conditions seclusion will be ended
- Informed of how to summon the attention of staff
- Informed that their fluid and food intake (balance) will be monitored and recorded if required
- Provided with food and drinks regularly (same to be recorded on seclusion observation record)
- Given access to toilet and washing facilities and will, if supervision is required, be supervised by a staff of the same gender.
- Have access to a bed and bedding
- Be advised that nursing staff relay messages to legal representatives, CQC and advocacy as required.

- Advised that consideration may be given to visits if considered safe to do so.
- Able to have sight of a clock at all times.
- Able to have access to radio/reading material where clinically appropriate and where safe to do so and the opportunity to engage in meaningful activity
- Encouraged to discuss with staff issues affecting their psychological presentation and safety.
- Informed that their family or carers will be informed of their situation if previously agreed in a positive behavioural support plan or crisis support plan, or advance statement. It is the responsibility of the Responsible Clinician to ensure the family/carers are informed.
- Access to a telephone if considered safe and clinically appropriate.

7.4.13 In exceptional circumstances when a patient may require seclusion on a host ward, this must be discussed with the management/oncall management team and an incident form completed. Clear plans must be made to ensure the `home` and `host` clinical team have an agreement to complete observations, clinical reviews and interventions for the patient. A patient must not be placed in seclusion on a ward that is not specific to their gender.

7.5 COMMENCEMENT OF SECLUSION

7.5.1 Authorisation for the decision to implement seclusion can be made by either the nurse in charge of the ward, a psychiatrist, or an approved clinician [Chapter 26.112]

7.5.2. The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion [Chapter 26.114]

7.5.3 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 [Chapter 26.112]

7.5.4 On commencement of seclusion the nurse in charge of the ward will immediately notify:

- The appropriate doctor who 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 [Chapter 26.116]
- The senior nurse on duty (to be locally determined) who will attend or contact the ward. This will be the Matron in working hours and the flow co-ordinator out of hours
- Complete an incident form and categorise this as Moderate (L3)

7.5.5 If the seclusion was authorised by a psychiatrist the first medical review will be that undertaken immediately prior to, or on the commencement of seclusion. Therefore, there will be no need for a further review within one hour [Chapter 26.116]

7.5.6 On being informed of the need to attend for an initial assessment/review of seclusion the doctor must make every effort to attend within an hour. This initial review should take priority over routine tasks and any potential or anticipated delay in meeting the hour deadline should be discussed with the Consultant on-call/delegated other and others on-call. This is to ensure that the delay is considered reasonable and appropriate given other competing clinical priorities.

7.5.7 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 an incident form that will be reviewed by senior managers. (This should be recorded as a - Incident Type: Mental Health Legislation, Cause Group: Other – MH Legislation, Cause 1: Seclusion Review Breach) The nurse in charge must ensure that this is escalated to the appropriate senior manager to discuss any risks this may pose.

7.5.8 The nurse in charge should ensure a Search is undertaken at the point of commencing seclusion and decide what the patient can take into the seclusion area/room; noting that the patient should never be deprived of clothing. [Chapter 26.113]

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 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
- The search should be carried out by staff of the same gender as the patient 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
- The patient should receive an explanation of the reason for their being in seclusion and for the search.
- Staff may decide what a patient can take into the seclusion area – this may include returning items at a later stage, 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 records. The list should be signed and witnessed by 2 staff as an accurate record of the items removed.
- The patient will remain under constant observations and if staff believe that they are concealing a hazardous article, despite a search having been undertaken, attention paid to this
- Removal of clothing or use of strong clothing is deemed a high-level restriction and has a significant impact upon privacy, dignity and human rights. In the exceptional event that this is being considered the matron or out of hours coordinator must be consulted in the first instance and an incident report to indicate any rational and actions taken

7.5.9 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 patient in seclusion.

7.5.10 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.

7.5.11 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 [Chapter 26.129] and placed in the patient's healthcare record and made available to the observing staff. As a minimum the care plan must include:

- Assessment and management of risks presented
- Steps to be taken towards the safe ending 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 and other resources to support engagement in meaningful activity
- Assessment of fluid and nutritional needs. Note that fluids should be offered to the patient every hour and recorded on a fluid chart if fluid input is considered a specific physical need or concern
- The monitoring of a patient's physical condition when parenteral medication (either deport or emergency medication or rapid tranquilisation) has been, or is due to be administered
- The minimum number of staff that are required to enter the seclusion room (see 6.2.9 above)
- Reference to a positive behavioural support plan or advance statement
- The patients' views regarding his/her being in seclusion

- Information about how relatives or carers are to be kept informed (dependent upon previously agreed positive behavioural plans or advance statements)
- Involvement of their advocate
- Activity plan

7.5.12 Attempts should be made to include the patient in the development of the seclusion care plan at the earliest opportunity [Chapter 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.

7.5.13 The patient should be provided with a copy of the care plan unless clinically contra-indicated. This could be a printed copy; a copy displayed at the window or could be verbally explained to the service user. This should be available in Easy read where appropriate. Any decisions to withhold care plans should be documented in the patient healthcare record

7.5.14 Advocacy – at the earliest opportunity the patient must be informed of their right to advocate (if not already done so) and their right to involve their advocate during the seclusion episode. The advocate should be invited to any Independent reviews of seclusion and support the patient's wishes related to the seclusion care plan. Visits whilst in seclusion should be supported.

7.5.15 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.

7.5.16 Family members should be notified of the use of seclusion if previously agreed in either a positive behavioural support plan or advance statement. If not agreed attempts should be made to discuss with the patient and a decision reached. Clinical judgment on informing family may be required. The outcome should be recorded in the notes.

7.5.17 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.

7.6 OBSERVATIONS AND RECORD KEEPING

7.6.1 Immediately after the commencement of seclusion, the Nurse in Charge will place the patient on a minimum of continuous eyesight observation (as

defined in the Observations of Inpatients Policy (from April 2022 will be the Safe, Supportive Engagement Policy of Inpatients – General and Enhanced). These observations must be undertaken by a suitable identified member of the clinical team. A collaborative decision will then be made between the Doctor and the Nurse in charge of the ward as to the appropriate level of observations required.

7.6.2 Throughout the period of seclusion there must be a suitably skilled professional 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 and are readily available within sight and sound of the seclusion area at all times [Chapter 26.118] and have the means of summoning urgent assistance if required [Chapter 26.119]

7.6.3 The level of observation of the patient is to be constant but the records must be at intervals of 5 minutes for the first hour then no longer than 15 minutes and recorded on the electronic seclusion observation record within the patient record.

7.6.4 The aim of these observations is to safeguard the patient, monitor and report on their condition and behaviour, and to help identify the earliest time at which seclusion can end [Chapter 26.121].

7.6.5 In recording these observations, the staff should remain mindful of recording relevant issues such as patient appearance, mood, level of awareness, activity, verbal interactions and any physical concerns or issues such as breathing, pallor or evidence of cyanosis [Chapter 26.124]

7.6.6 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” [Chapter 26.125]

7.6.7 Consideration should be given to the gender of the staff observing the patient: noting consideration of the patient’s previous trauma history [Chapter 26.120] and issues of dignity and privacy.

7.6.8 The seclusion record must identify the time at which seclusion commenced [Chapter 26.115], with the principle entry being made by a qualified nurse. A record of the commencement should also be made in the patient’s healthcare record as a review note.

7.6.9 In line with the Trust policy for the Observations of Inpatients (from April 2022 will be the Safe, Supportive Engagement Policy of Inpatients – General and Enhanced), the nurse in charge will ensure that wherever practicable an individual does not undertake a period of observation within eyesight observations for an uninterrupted period of longer than one hour.

7.6.10 Seclusion must be recorded in the electronic patient record. The seclusion record should include:

- details of who authorised the seclusion
- the date and time of commencement and reason(s) for seclusion
- details of items taken into the seclusion room/area
- If/when a relative/carer and/or advocate was informed of the commencement
- recorded observations at 15-minute intervals
- physical health monitoring as locally performed (NEWS2 or AVPU)
- who undertook nursing reviews and what was observed?
- who undertook medical, internal MDT and independent MDT reviews and what was observed and recommended
- at each review, if seclusion was not ended, explicit rationale as to why seclusion continues and what needs to occur in order for seclusion to end.
- date and time seclusion was ended, and who authorised this

7.7 PATIENT EXPERIENCE AND OPPORTUNITY TO ENGAGE

7.7.1 Staff should work with the person to identify needs and risks will be and record these in the seclusion care plan. 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.

7.7.2 The person must have access to showering and hygiene facilities and items and be supported to discuss how they can safely use these. If for any reason this cannot be provided this must be clearly risk assessed and documented and discussed as part of reviews. If this includes no access to ensuite facilities this must also be incident reported with a plan to reintroduce at the earliest opportunity.

7.7.3 If a patient is denied clothing or personal items for the purposes of risk management, this must be clearly explained to the patient and recorded in the patient's healthcare record. This will form part of the careplan is this continues to be necessary, with a plan for reintroduction of these items at the earliest opportunity. (See also 7.5.8)

7.7.4. Patients should be encouraged to make an advance statement with respect to the use of restrictive practices if capable and willing to do so.

7.7.5 An accessible version of this policy must be made available to the patient and opportunity to discuss seclusion with a member of MDT during reviews.

7.7.6 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 and shared with them.

7.7.7 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 [Chapter 26.167]. If the patient is able and willing, then this should be undertaken by someone of the patient's choice [Chapter 26.169] Remorse and Regret should not be used as part of the assessment or debrief as they are not appropriate measures of wellbeing and engagement.

7.7.8 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 [Chapter 26.170].

7.7.9 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 [Chapter 26.168]

7.7.10 **Delivering Equality and Supporting diversity and protected characteristics**

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 and protected characteristics 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 or needs, e.g., 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. Planned access to meaningful engagement and activity should be incorporated

7.8 REVIEWS OF SECLUSION

For the purpose of this policy the reviews of patients in seclusion have been divided into

- Nursing reviews
- Medical reviews
- Internal Multi-Disciplinary Team reviews
- Independent MDT reviews
- Prolonged seclusion reviews and process
- Reviews during the night

General principles for seclusion reviews are that

- Every effort should be made undertake the review within the seclusion room/area, but only when it is considered therapeutic and/or safe to do so.
- The names and designations of all staff entering the seclusion room will be recorded in the seclusion record.
- Reviews will remain as per Code of Practice
- There must be a clear statement that outlines "whether seclusion needs to continue or should be ended, as well as to review the patient's mental and physical state" [Chapter 26.126]

7.8.1 NURSING REVIEWS

7.8.1.1 Nursing reviews must take place every two hours by two registered nurses, one of whom was not directly involved in the decision to seclude [Chapter 26.134]. This must be recorded in the patients record. Where 2 registered nurses are not on duty on the same ward, the second nurse can be called to attend from another ward or area to support the review. If the 2nd Nurse is unable to attend the ward this can be undertaken over the telephone or skype and recorded as such within the review.

7.8.1.2 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 [Chapter 26.135]

7.8.1.3 A nursing review cannot end seclusion however can make recommendations to the Dr for an earlier joint review if it is felt seclusion can be ended sooner. Reviews can take place over the telephone if the Dr is delayed in attending

7.8.1.4 A nursing review should consider any changes to the careplan that will improve the overall experience or safety of the patient, following recorded risk assessment. This may include access to items, contact with family or a general review of the plan with the patient.

7.8.2 MEDICAL REVIEWS

7.8.2.1 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. [Chapter 26.116]

7.8.2.2 If after the first medical review the decision is that seclusion should continue then a seclusion care plan should be developed in collaboration with clinical staff.

7.8.2.3 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
- Have attended the relevant RESPECT training

7.8.2.4 Medical reviews will take place every four hours from the commencement of seclusion until the first Internal Multi-Disciplinary Team review takes place [Chapter 26.131]. Four hourly reviews should continue if there is cause for concern related to physical health or environmental issues and safety. Non engagement is not a reason to reduce to BD reviews (twice in 24 hours), more a reason to maintain 4 hourly reviews until a conversation and agreement with the patient can be reached.

7.8.2.5 Following this first Internal Multi-Disciplinary Team review further medical reviews should continue at least twice in every 24hr period [Chapter 26.132] unless to remain at 4 hourly.

7.8.2.6 At least one of these twice daily reviews should be by the patient's Responsible Clinician, or other consultant/identified Dr out-of-hours [Chapter 26.132]

7.8.2.7 The outcome of the medical reviews should be recorded in the patient's healthcare record.

7.8.2.8 Medical reviews should be carried out in person (for medical reviews during the night, see section 6.5.7) and provide the opportunity to evaluate and amend the seclusion care plan [Chapter 26.133]. Such reviews should

- Review the patient's physical and psychiatric health
- Assess any adverse effects of medication
- Review the level of observations required
- Reassess prescribed medication
- Assess the level of risk to others
- Assess 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 to include activity and access to items

7.8.2.9 If it is agreed to end seclusion the Dr should identify with the team the plan for reintegration and support needed once back on the ward.

7.8.3 INTERNAL MULTI-DISCIPLINARY TEAM REVIEWS

7.8.3.1 The Internal Multi-Disciplinary Team should review the patient as soon as is practicable [Chapter 26.137]. This should be within 24 hours of seclusion commencing.

7.8.3.2 Internal MDT reviews will take place within every 24hrs throughout the seclusion episode [Chapter 26.139].

7.8.3.3 Membership of this Internal MDT will include a Responsible Clinician, the senior nurse on the ward, and staff from other disciplines normally involved in the patient's care. Advocacy should be invited.

7.8.3.4 At weekends or public holidays the membership of this review team can be limited to a Responsible Clinician (or the person acting on their behalf) and the senior nurse on duty, However, the RC and senior nurse must hold a joint review.

7.8.3.5 These reviews should "evaluate and make amendments" to the seclusion care plan [Chapter 26.140]

7.8.3.6 The outcome of the internal MDT reviews should be recorded in the patient's healthcare record.

7.8.4 INDEPENDENT MULTI-DISCIPINLARY TEAM REVIEWS

7.8.4.1 If the period of seclusion continues for longer than 8hrs consecutively or 12hrs intermittently during a 48hr period then an independent MDT review should be undertaken [Chapter 26.141]

7.8.4.2 This review should be undertaken by end of next working day after commencement of seclusion following the Internal MDT.

7.8.4.3 Membership of this independent MDT will include a Responsible Clinician, a senior nurse, other professionals not involved in the decision to place the person in seclusion and an IMHA if available and if the patient has one. Out of hours this may be the Higher trainee or SAS Doctor acting on behalf of the Approved clinician.

7.8.4.4 It is good practice for this team to consult with staff involved in the decision to authorise seclusion wherever possible [Chapter 26.142]

7.8.4.5 These reviews should "evaluate and make recommendations, as appropriate, for amendments" to the seclusion care plan [Chapter 26.143]

7.8.4.6 The outcome of the independent MDT reviews should be recorded in the patient's healthcare record.

7.8.5 PROLONGED SECLUSION (Over 48hrs)

7.8.5.1 The use of seclusion over 48hours is notifiable to the Trust Management and Clinical Directorate Leadership Team. This must be incident reported as a `Moderate` (Level 3 incident).

7.8.5.2 Following initial notification via incident form of the ongoing seclusion, an update must be given every 48hours, to the Clinical Directorate Leadership Team. This can be via telephone call or email.

7.8.5.3 If a patient remains in seclusion for more 72 hours, an independent Clinical Directorate Leadership Team review will be arranged. The Senior Matron/ Deputy Head of Nursing/Nurse Consultant and/or Consultant Psychiatrist from another team will undertake the review. Where possible this will include a member of the Respect team The aim of the review is to ensure appropriate treatment is being delivered, that the care plan is delivering high quality care and to assess the impact and trauma of seclusion on the patient.

7.8.5.4 The Clinical Directorate Leadership Team review must also include an explicit assessment of human rights, indicating how the breach of rights is proportionate to the risk presented by the patient. It must ensure that treatment in seclusion is humane, respectful and promotes connection with family and carers wherever and however possible. Advocacy must be supported.

7.8.5.5 For all seclusions over 72hours, the allied health professional associated with the unit must undertake an assessment to consider how activity, occupation and engagement can be incorporated into the patient's seclusion plan. Where it is deemed unsafe to provide any materials or activities, this must be clearly documented and agreed by the MDT. The isolative experience of seclusion will likely cause significant trauma and the role of the MDT is to minimise this wherever possible, whilst managing the ongoing imminent and ongoing risk of harm.

7.8.5.6 The outcome of all seclusions over 72 hours must be shared with the Clinical Directorate Leadership Team . This can be done by telephone or email.

7.8.5.7 In the highly unusual event that a patient is in seclusion for over 7 days, the Clinical Directorate Leadership Team will arrange an Executive Clinical Panel review of the patient. This must take place between 7 – 10 days. The clinical team will ensure that the MDT is available to support this external review.

This review will consider the clinical care and treatment of the patient and any suggestions for care improvement. It is asked that the reviewers complete a summary of their review and recommendations either by adding to the patients records or by a brief report summary that can be sent to the care team and added to the persons records. This outcome report should be shared with the Clinical Commissioning Group Chief Nurse for information. The Director of Quality or Medical Director should be invited. Safeguarding must be involved and the Respect team must attend and/or Lead Nurse.

7.8.5.8 The Matron for the service will ensure the Trust extended seclusion reporting requirements are completed as per policy, which will include regular updates and ongoing incident reports for every further 7 days the person remains in seclusion.

7.8.6 NIGHT TIME REVIEWS

7.8.6.1 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

7.8.6.2 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. (see section 6.5.7.3 below)

7.8.6.3 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.

7.8.6.4 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.

7.8.6.5 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.

7.8.7 FLEXIBLE SECLUSION

7.8.7.1 Flexible seclusion – 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 distress and engagement under a lesser degree of restriction without ending the seclusion episode.
Examples of flexible seclusion include

- Supporting time in their bedroom to take a shower
- Specific time in the communal areas of the ward
- Meals in the general area of the ward

7.8.7.2 Any flexible seclusions arrangements must be discussed and agreed with the patient and made clear that the seclusion has not yet ended.

7.8.7.3 The seclusion careplan must be updated.

Standards related to seclusion must be maintained during flexible seclusion. Seclusion has not ended during flexible seclusion

7.9 ENDING SECLUSION

7.9.1 Seclusion should be ended immediately when it is determined that it is no longer warranted [Chapter 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

7.9.2 Opening a door for short periods (eg: 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 [Chapter 26.146]

7.9.3 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 [Chapter 26.148]

7.9.4 Following all episodes of seclusion there should be a post-incident review/debrief to ensure organisational learning and support for all parties involved, including patients. [Chapter 26.167]

7.10 DEBRIEF AND RE-INTEGRATION BACK ON TO THE WARD

7.10.1 Following a period of seclusion the clinical rationale for its use should be explored with the patient, and they should be supported in the process of re-integration to normal unit activities. Time should be set aside to facilitate this process with a nominated member of the MDT.

7.10.2 This discussion will include the following:

- Does the patient understand why they were secluded?
- How does the patient feel about the necessity, reasonableness and appropriateness of the use of seclusion?
- How does the patient feel now, after the event?
- How can the need for any further episodes of seclusion be avoided in the future?

7.10.3 The discussion will inform the review of the patient's ongoing Care Plan or Behaviour Support Plan and can be incorporated into the patient's Advance Statement.

7.10.4 Post-incident debrief is available to both staff and patients. Any member of Trust staff who requests support post incident can access staff

wellbeing service. Local debrief and support is available through line management.

7.11 STRONG CLOTHING

7.11.1 The use of strong clothing or bedding should not be the first choice and should only be used if there is a case where normal attire or bedding may present a risk to the patient or others. The authorisation for the use of strong clothing or bedding will be by the patient's RC and MDT, or other RC if unavailable, following assessment by an MDT. Out of hours this MDT assessment may consist of the duty doctor and Nurse in charge of the ward who should then consult with the RC on call to authorise. [Chapter 26.162]. Where strong clothing is used – this should be incident reported.

7.11.2 Any use of strong attire or bedding should be proportionate to the perceived risk and last no longer than necessary. The nurse in charge of the ward or an MDT can authorise a return to normal clothing or bedding following an assessment of the continuing risks. These risks will require ongoing assessment and review. [Chapter 26.165]

7.11.3 The use of a positive behavioural support plan or crisis support plan should identify strategies that may help avoid the use of strong clothing or bedding and provide the patient with guidance on what is required of them to have normal clothing and bedding [Chapter 26.166]

7.12 MEDICATION

7.12.1 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.

7.12.2 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.

7.12.3 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.

7.12.4 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'

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.

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

7.12.6 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' (SD11) 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 in the patient's healthcare record
- A pulse Oximeter should be available

7.12.7 If a patient has been sedated then they should be monitored 'within eyesight' observation (Observations of Inpatients policy (from April 2022 will be the Safe, Supportive Engagement Policy of Inpatients – General and Enhanced)) by a qualified nurse, until such time as a medical review indicates otherwise [see Chapter 26.122]

7.12.8 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 patients in seclusion 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 patient's 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.

7.13 MECHANICAL RESTRAINT OR OTHER HARMFUL INTERVENTIONS

If a service user has been brought in by the police or secure transport services and mechanical restraint has been used this must be indicated on the incident form. This must be addressed and reviewed as part of the initial assessment following, and consideration given to physical and psychological wellbeing. Additional support and action may be required depending on the nature of the intervention (for example use of a taser or irritant spray) and additional monitoring and reviews. This should be clearly indicated in the first seclusion reviews and form part of the careplan.

7.14 SELF-HARM

7.14.1 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".

7.14.2 The decision and rationale for using seclusion for 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 behaviours.

7.15 VISITS

7.15.1 The code of practice recognises that for patients who are in seclusion for a prolonged time visits may be appropriate [Chapter 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

7.15.2 Official visitors should consult with the nurse in charge of the ward before visiting a patient in seclusion. 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 that visitor may be at risk.

7.15.3 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. Safeguarding advice should be sought and explicit consideration of human rights aligned to the requirements for extended seclusion met.

7.15.4 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.

7.15.5 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 Clinical Directorate Leadership Team prior to the visit commencing.

7.15 APPEAL

7.15.1 If a patient or patient's representative wants to make any representation regarding the use of seclusion it should be made to the Clinical Director for the Clinical Directorate Leadership Team , or the Clinical 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.

7.16 SECLUSION MONITORING ARRANGEMENTS

7.16.1 The use of seclusion will be monitored through a variety of mechanisms.

7.16.2 The clinical team will ensure the appropriate notifications are completed and that the Clinical Directorate Leadership Team are notified. Seclusions lasting under 48 hours will be subject to an audit of adherence to the Code of Practice by the Matron or nominated cover. This audit will take place via the Trust approved Audit tool and will be fed back to the clinical team. Any issues of compliance will be discussed with the MDT and actions to address for seclusion episodes will be met

7.16.3 All seclusion audits will be reviewed through the Reducing Restrictive Practice Group attended by ward managers and clinical leads. Thematic analysis of the use of seclusion will take place and consideration of any actions to reduce its use will be considered

7.16.4 Trustwide seclusion use and the themes identified by the RRPG will be overseen by the Least Restrictive Practice Oversight Group. This group reporting to the Mental Health legislation Committee will ensure that learning takes place, variation from the Code of Practice is verified and actions/learning has taken place to ensure future adherence to the safeguards of the Code of Practice.

7.16.5 The LRPOG will also 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

8 PROCEDURE FOR SEGREGATION

8.1 **Definition of long-term segregation**: Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a 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. For the purposes of this policy, it should be noted that **segregation** will be managed with the same safeguards as Long Term Segregation; this is in alignment with the CQC recommendations from Out of Sight (2020)

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 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 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 (Mental Health Act Code of Practice, 26.150).

8.2 The Trust recognises that on rare occasions, and for cogent clinical reasons, a patient within an inpatient area may need isolating from their peer group, staff or the wider ward community for a prolonged period due to the intractable or resistant nature of their presentation and ongoing presenting risks.

8.3 The multidisciplinary review that considers the use of segregation should include an IMHA if the patient has one [Chapter 26.150]

8.4 Wherever segregation is considered, the views of family/carers should be elicited where appropriate and where indicated in the patient's Positive Behavioural Support Plan or careplan. This is the responsibility of the Responsible Clinician.

8.5 For a patient to be considered for segregation a multi-disciplinary team must consider it necessary, and agreement must be obtained from the responsible commissioning authority [Chapter 26.150]

8.6 The following individuals must be informed that Segregation has been recommended and approved by the Clinical Directorate Leadership Team and the Commissioners:

- Medical Director / Director of Nursing
- Responsible Person Use of Force (Director of Quality)
- Consultant Nurse: Restrictive Practice
- Head of Mental Health Legislation
- Head of Safeguarding

8.7 Patients in segregation should be cared for in conditions of least restriction necessary to maintain safety [Chapter 26.151]

8.8 Patients managed under segregation should have access to the following, away from the wider ward community [Chapter 26.152]

- A bedroom
- Bathroom facilities (toilet/washing facilities)
- Relaxing lounge area
- Secure outdoor area
- Range of activities of interest and relevance to the patient

8.9 Patients should continue to have contact with staff, and should not automatically be deprived of access to therapeutic interventions [Chapter 26.152]

8.10 Segregation plans should aim to end patient isolation as soon as practicable and re-integrate the patient back into the wider ward community [Chapter 26.152] and outline how patients are to be made aware of what is expected of them so that the segregation can be terminated [Chapter 26.158]

8.11 It is the responsibility of the care team to determine the level of enhanced observations the patient should be subject to, remaining mindful that Chapter 26.154 states that as a minimum there should be a written observation record made by a supervising staff on at least an hourly basis.

8.12 The level of enhanced observations should be clearly documented in the segregation careplan

8.13 Patients in segregation will be reviewed by the nurse in charge of the ward at every shift handover. The aim of this is to ensure that the patients 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 health care record by the nurse in charge on each occasion.

8.14 The segregation care plan must:

- identify risks and articulate why long-term segregation is necessary
- summarise the planned treatment/care/activity from a range of disciplines but MUST include Occupational therapy and psychology.
- Make the plan available and accessible according to patient need
- specify the observation levels required. Minimum of 1 hour.
- the conditions under which segregation may be ended
- 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

8.15 Patients in segregation should be managed in an appropriate environment commensurate to the risk presented. This may include the patient's own bedroom. The patient must have access to a staff call system.

Segregation Reviews

8.16 Patients in segregation will have their situation formally reviewed by a Responsible Clinician or delegate out of hours at least once in any 24hr period [Chapter 26.155]

8.17 Patients in segregation will have at least three face-to-face medical reviews each week. If the review is performed by a CT/ST or Specialty Doctor who is not an AC they will need to discuss the situation with the RC, (or covering RC) and document that this has occurred.

8.18 Patients in segregation will be reviewed weekly by their multi-disciplinary care team. This review should include an IMHA where appropriate [Chapter26.155]

8.19 There is a need for periodic reviews of patients in segregation by a senior professional not involved in the case but within the Trust [Chapter 26.155]. This duty will fall to the Clinical Directorate Leadership Team Where appropriate the Clinical Director or Head of Nursing may request to involve clinicians from a diverse background to ensure representation of need is considered and this is important for those from a BAME background or protected characteristics.

An **Internal Clinical Review** of ongoing Segregation will be arranged and attended **monthly** by:

- Clinical Director
- Head of Nursing
- Responsible Person: Use of Force (Director of Quality)

In attendance to support discussion and adherence to legal duties and rights :

- Human Rights Officer
- Head of Mental Health Legislation
- Head of Safeguarding

Deputies are permissible providing they have the knowledge required

Given the seriousness and significant ongoing restriction of a person in segregation, SHSC will require Executive Clinical assurance of any individual in segregation. This will be achieved through a monthly assurance panel. Details of the panel and membership can be acquired from the Standard Operating Procedure. The panel will include a senior Quality lead from the commissioning body. The responsible commissioning authority will be kept informed of the outcomes of these monthly reviews. [Chapter 26.155].

8.20 Whenever 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 [Chapter 26.156]

8.21 The purpose of reviews for patients in segregation 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 psychological wellbeing [Chapter 26.157]. It should also include a discussion on whether an alternative placement may be required to support ending of segregation.

8.22 The decision to end 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 [Chapter 26.157]

8.23 Should a patient in segregation require temporary transfer to a seclusion room from a normal bedroom as a result of an acute behavioural disturbance then the procedure for seclusion should be followed [Chapter 26.150] until such time as the behavioural disturbance is over and the care team consider it appropriate to reinstate segregation.

8.24 **SEGREGATION REPORTING ARRANGEMENTS**

Segregation will be reported via the Mental Health Legislation Operational Group and recorded in the Trust wide Integrated Performance and Quality Review (IPQR).

The responsible executive will report the initiation and ongoing use of segregation to the Trust Board.

Compliance with policy will be monitored by the Nurse Consultant for Restrictive Practices and reported to the Responsible Person for the Use of Force.

Segregation will be reported via Trust incident reporting system, Ulysses and into the MHSDS (mental health dataset). The Responsible Person will be accountable for ensuring reporting via MHSDS.

9 USE OF EMERGENCY SERVICES

In the unlikely event that teams feel the need to ask for support of the police or other emergency services they must be clear that the Clinical team remains responsible at all times for the care of the patient. This is to include support of the patient, monitoring of the patient and follow up related to any restrictive practices used. The nurse in charge of the ward must ensure that all practices and approaches are person centred and human right respecting.
As part of the Use of Force Act (2018) guidance all police officers in attendance to Mental health units should wear and have on body cameras

10 IN THE EVENT OF A 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 patient should be evacuated alongside other patients and enhanced observations commenced.
• 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.

11 DEVELOPMENT, CONSULTATION AND APPROVAL

This policy has been developed by consultation across the Trust using relevant staff networks and forums, and the Trust communications

systems. Feedback and learning from incidents have been included. The Reducing Restrictive Practice Operational Group has contributed to its review and general feedback when talking to service users and staff had been considered. Legal advice was also sought to ensure compliance with the MHA Code of Practice.

12. Audit, Monitoring and Review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Adherence to policy requirements	Review by Matrons and Heads of service via - local audits - reporting to Restrictive Practice Oversight group	Matrons and Heads of Nursing. Least restrictive Practice Oversight Group.	Quarterly	Least Restrictive Practice Oversight Group	Matrons and Heads of Nursing	Least Restrictive Practice Oversight Group

13. Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
Upload revised policy onto intranet and remove old version	Head of Communications	October 2022	
Develop summary document to support matrons to share at team level	Nurse Consultant – Least Restrictive Practice	15/02/2022	Complete and circulated January 2022
Develop careplan guidance	Nurse Consultant – Least Restrictive Practice	15/02/2022	Completed and circulated January 2022
Develop team audit template	Nurse Consultant – Least Restrictive Practice	30/09/2021 – complete and in use	Complete. Reviewed March 2022 and amendments made. For relaunch March 2022
Agree reporting template for prolonged seclusion (7 days+)	Head of Nursing-Acute Care	Complete and included as appendix	Complete and included in policy
Develop and Deliver training on Policy and Practice requirements	Nurse Consultant – Least Restrictive Practice in conjunction with Training department	30/09/21-complete Ongoing into 2022	In progress. Forms part of RESPECT training. Individual sessions delivered at team level and via QIF.
Share at team level via discussion or teaching and learning sessions	Ward Manager and Matron	30/04/2022	In progress. Forms part of RESPECT training. Individual sessions delivered at team level and via QIF.
Review standards via Audit and quality assurance	Matron	3 months after implementation via quarterly reporting	

14. Dissemination, Storage and Archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0, 2.0, 3.0, 4.0	Versions no longer available			
5.0	March 2017	Removed		
6.0	May 2018 – May 2021	Removed		
7.0	September 2021	September 2021	September 2021	
9.0	March 2022	March 2022	March 2022	
9.1	September 2022			

15. Training and Other Resource Implications

Staff are provided training on best practice procedures for supporting patients nursed in seclusion and segregation during mandatory Personal Safety Training, RESPECT training and via a specific training programme.
The RESPECT training covers elements of Seclusion and segregation particularly in relation to preventative approaches and de-escalation and standards in relations to seclusion and segregation use.
A digital summary and guide will be provided for staff to support this policy and it will work hand in hand with the Use of Force Policy and Least Restrictive Practice Strategy. Matrons will be expected to deliver the summary guide at local team level via interactive and discussion sessions to enable understanding and compliance with standards as well as promotion of prevention and use of alternatives.
Training needs for a specific clinical area should be based on the training needs analysis and in conjunction with the Matron and RESPECT team leads.
The identification, attendance and monitoring of training and training needs is the responsibility of the Ward Manager and Matron.
Training will be reviewed as part of team governance arrangements, as part of the Trust monitoring of training compliance and reported via the Least Restrictive Practice Oversight Group and the Training Department governance groups.

- All staff will receive RESPECT training as appropriate to the level of patient contact and in line with the needs of the patient group.
- All staff are to be trained in either Basic Life Support or Advanced Life support, dependent upon role and the Training Needs analysis
- All staff will receive some form of Human right training either as a bespoke programme or via a session within the RESPECT training. Needs will be identified via the Training Needs analysis.
- Training on the seclusion policy and its standards and application into practice will be developed in a variety of forms dependent upon the staff role. Some of the standards are covered with the current RESPECT training and further work is underway to develop more detailed and advanced packages to support knowledge base and skill.
- A training session on the implementation of electronic seclusion recording (inc NEWS 2) is available and has been implemented during 2021. This is to support standards of recording and accurate reporting.
- Human rights training, autism training and trauma informed practice.

16 Links to Other Policies, Standards (Associated Documents)

Mental Health Act 1983
Code of Practice, Mental Health Act 1983 (2015)
Human Rights Act, 1998
Mental Capacity Act (2005)
Use of Force Act (2018)
Race Relations Amendment Act (2000)
Equality Act (2010)

CQC Out of Sight (2020)
NICE Guidance NG10 – May 2015
Mersey Care NHS Foundation Trust Policy for the Use of Rapid Tranquillisation (SD11)
Mersey Care NHS Foundation Trust Policy for Supportive Observations (SD04)
Mersey Care NHS Foundation Trust Policy for the use of seclusion and Long term segregation (SD28)
Devon NHS Foundation Trust Policy for Seclusion, De-escalation and Long Tern Segregation (June 2021)

17 Contact Details

Title	*Name*	*Phone*	*Email*
Nurse Consultant – Restrictive Practice	Lorena Cain	0114 2718331	**Lorena.cain@shsc.nhs.uk**
Heads of Nursing	Emma Highfield Christopher Wood Simon Barnitt	0114 2716310 (switch board)	**Kirsty.DallisonPerry@shsc.nhs.uk** **Christopher.wood@shsc.nhs.uk** **Simon.barnitt@shsc.nhs.uk**
RESPECT team leads	Greg Hughes Bernard Turner	0114 2716802	**Greg.hughes@shsc.nhs.uk** **Bernard.turner@shsc.nhs.uk**
Mental Health Legislation	Jamie Middleton	0114 2118110	**Jamie.middleton@shsc.nhs.uk**
Human Rights Officer	Tallyn Gray	0114 2263666	**Tallyn.gray@shsc.nhs.uk**
Safeguarding Lead	Hester Litten	0114 2711050	**Hester.litten@shsc.nhs.uk**

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: Lorena Cain 24/1/2022	**YES, Go to Stage 2**

Stage 2 Policy Screening and Drafting Policy - 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 and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy 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**		
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Name /Date

This policy can be applied to all patients within in patient settings within SHSC. It recognises that there are protected characteristics, and that care delivery is required to be person centred, culturally appropriate and equal and diverse. When applying this policy into practice staff will have the relevant skills and knowledge, access to experts and specialist support and regard for where the careplan needs to take account of equality and diversity. The careplan will inform and support this

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Yes Director of Nursing
2.	Is the local Policy Champion member sighted on the development/review of the policy?	Yes Nurse Consultant for Restrictive Practice
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	Revised policy
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Yes
5.	Has the policy been discussed and agreed by the local governance groups?	Yes Via Inpatient wards Via reducing restrictive practice group.
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	Yes CQC Out of Sight-2020 Use of Force Act - 2018
	Template Compliance	
7.	Has the version control/storage section been updated?	Yes
8.	Is the policy title clear and unambiguous?	Yes
9.	Is the policy in Arial font 12?	Yes
10.	Have page numbers been inserted?	Yes
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Yes
	Policy Content	
12.	Is the purpose of the policy clear?	Yes
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Yes
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	Yes
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Yes
16.	Does the policy include any references to other associated policies and key documents?	Yes
17.	Has the EIA Form been completed (Appendix 1)?	Yes
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Yes

19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Yes
20.	Is there a plan to review audit compliance with the document?	Yes
21.	Is the review date identified, and is it appropriate and justifiable?	Yes

Appendix C

Risk Assessment for Bed Base/Mattress in Seclusion

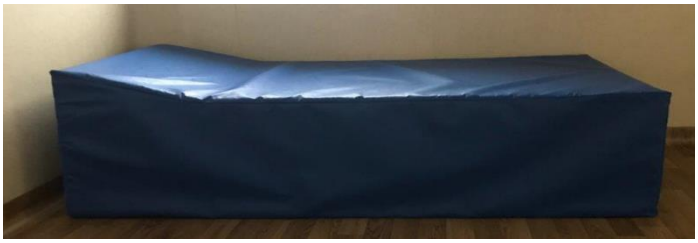
Guidance and record keeping for inpatient staff: -

All mattresses in seclusion suites and in bedrooms are to Crib 7 specification. This meets the necessary fire requirements whilst maintaining some of the potential pressure relief requirements.

As outlined in the Trust's Use of Seclusion Policy and the criteria identified within the Mental Health Code of Practice [Chapter 26.109], all seclusion rooms should have limited furnishings which should include a bed, pillow, mattress, and blanket or covering. This is to support comfort and aid sleep of the service user in the room.

As standard, all seclusion suites will come with a thick bed base/mattress, as shown in Figure 1:

Figure 1: Standard Seclusion Suite Bed Base/Mattress



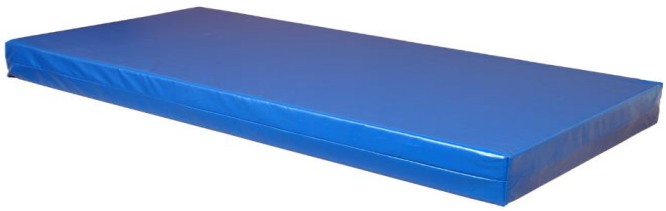
All seclusion rooms will have the bed base/mattress readily available in the room for use at the point of entering seclusion unless a recorded risk assessment has indicated this is not safe and a floor type mattress needs to be used. It is expected this will be in exceptional circumstances. The floor type mattress, in this event, would be the service users mattress from their bedroom.

If during seclusion the bed base/mattress becomes a risk, this can be replaced by the standard bedroom mattress from the service user's bedroom. This again should only be in exceptional circumstances and be supported by a recorded risk assessment. If a floor type mattress (one from own bed, see Figure 2) is used then this should be reviewed at every review schedule to consider if the bed base one can be re-introduced.

Where both the bed base/mattress and/or the service user individual bedroom mattress are assessed as a risk then an alternative will need to be discussed with the matron or relevant other out of hours to establish a further alternative.

It is imperative that service users are as comfortable as possible whilst in seclusion and that any alternative from the bed base/mattress is clearly risk assessed

Figure 2 : Standard Bedroom Mattress



Appendix C

Risk assessment – THIS IS A WORKED EXAMPLE

To be added to service user record

Date and time of assessment:

Assessor undertaking risk assessment: (Name and designation)

Overview of risk assessment - include all presenting risks (relating to service user and seclusion suite, particularly in relation to depth of mattress to use). Please also consider if there is a risk of the service user damaging the alternative mattress (i.e. chewing, picking) and whether the alternative may require further mitigation and review of use:

Example one

No risks identified with XXX having the bed base/mattress whilst in seclusion. Staff on her observations and doing nursing and medical reviews will review this to ensure this remains safe to use.

Example two

XXX is very distressed and angry about being in seclusion and there are concerns that she may use the bed base/mattress to climb or block the entrance to the seclusion room, making it difficult for staff to enter or view her. On this basis the risk assessment indicates that XXX is to be provided with the mattress from her bedroom and that this will be reviewed at each nursing and joint review to see if the bedbase mattress can be reintroduced. Family and advocacy are to be informed of this and this will be reflected in her seclusion careplan. An incident form will be completed to report the need to use a floor type mattress. There are no risks indicated with using the mattress from her bedroom in terms of safety however it is noted that this is likely to be less comfortable as it is floor based

Example three

Following being in seclusion for the last 2 hours XXX has tipped the bed base/mattress onto its side and is hiding behind it making observations of her safety and physical state very difficult. Discussed at part of MDT and agreed for the next few hours the seclusion bed base/mattress will be replaced with her bedroom mattress which is floor based. This will be reviewed at each nursing and joint review. Family and advocacy are to be informed of this and this will be reflected in her seclusion careplan. An incident form will be completed to report the need to use a floor base type mattress.

Decision on mattress to provide in seclusion room:

☐ Keep standard seclusion room bed/base mattress

☐ Use alternative mattress i.e. bedroom mattress

Appendix C

Rationale for any other alternative to bedroom mattress used

Where an alternative mattress has been used, there should be regular reviews throughout seclusion period to revisit the risk assessment and appropriateness of this. All use of alternative mattresses should be incident reported

☐ Complete and add to service user insight record

☐ Use to inform care plan

☐ Inform service user, family, and advocate

☐ Incident report completed

If an alternative mattress has been moved into seclusion room, this must be Clinell wiped before returning to the bedspace.

Appendix C

Risk Assessment for Bed Base/Mattress in Seclusion

To be added to service user record

Date and time of assessment:
Assessor undertaking risk assessment: (Name and designation)

Overview of risk assessment - include all presenting risks (relating to service user and seclusion suite, particularly in relation to depth of mattress to use). Please also consider if there is a risk of the service user damaging the alternative mattress (i.e. chewing, picking) and whether the alternative may require further mitigation and review of use:

Decision on mattress to provide in seclusion room:

☐ Keep standard seclusion room bed/base mattress

☐ Use alternative mattress i.e. bedroom mattress

Appendix C

Rationale for any other alternative to bedroom mattress used

Where an alternative mattress has been used, there should be regular reviews throughout seclusion period to revisit the risk assessment and appropriateness of this. All use of alternative mattresses should be incident reported

☐ Complete and add to service user insight record

☐ Use to inform care plan

☐ Inform service user, family, and advocate

☐ Incident report completed

If an alternative mattress has been moved into seclusion room, this must be Clinell wiped before returning to the bedspace.

Risk Assessment for Seclusion Mattressv5.

Appendix D

Sheffield Health and Social Care NHS Foundation Trust

CONFIDENTIAL BRIEFING REPORT FOR SECLUSION CONTINUING OVER 7 days (following alert by incident form and escalation by team)

This review should be completed by the Clinical Directorate Leadership Team or oncall manager is made aware of the incident and it is returned to the Patient Safety Team and escalated to the Director of Operations, Exec Medical Director, Exec Director of Nursing and Director of Quality

For Completion By The Patient Safety Team	
Date Request For Report Sent Out	
Date Report Due To Be Completed	
Date Report Received	

Reviewer's Details			
Reviewer's Name		**Reviewer's Job Title**	
Reviewer's Tel. no		**Reviewer's E-mail**	
Name of Senior Manager Informed			

Ulysses Reference (will be linked to initial seclusion incident form and 48 hour incident report on prolonged seclusion and 72 hour incident form)	
Date of initial Incident which led to seclusion	
Date of this report	
Directorate	
Location of Incident (Unit / Team / Department)	

Date and Time Seclusion Commenced	

Patient Details	
Name	
Insight number	
Age	
Gender	Choose an item.
Any protected characteristics (gender, disability, ethnicity etc)	
MHA Status at the time of the incident (if applicable)	
Name of advocate	

Appendix D

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Duty of Candour – The patient / family / carer must be informed of the incident when the level of harm to the patient is moderate or above.???	
Degree of Harm (Degree of harm caused by the Trust)	Choose an item.
Being open - Has the incident been discussed with the Patient / Relative / Carer?	Yes ☐ No ☐
If No - please state the reason below for not informing the patient / relative / carer:	
If Yes - please answer the following:	
When was the patient / family / carer informed:	**Discussed with the patient at seclusion reviews**
How was the patient / family / carer informed:	☐ Face-to-Face ☐ Over the telephone ☐ Letter
Details of patient / family / carer who was informed:	

Events leading up to, and rationale for seclusion
1. What was tried prior to seclusion?
2. Was restraint utilised prior to seclusion and is the use of restraint ongoing to support interventions? If Yes describe what levels were used.
3. Give an overview of all PRN and RT being utilised

Sheffield Health and Social Care NHS Foundation Trust

4. Have physical health checks been carried out as per policy?
5. Have the Independent Reviews taken place as per Policy? What are the recommendations?
6. Have the Internal MDT's taken place as per policy? If not describe why not.
7. Have the Nursing Reviews taken place as per policy? If not describe why not.
8. Have the Medical Reviews taken place as per Policy? If not describe why not.
9. Have 15 minute observations been carried out? If not describe why not.
10. Is there a clear rationale as to why seclusion needs to continue?
Please append the patients seclusion careplan

Are there any Safeguarding issues (Adult or Child)? If so what action have you taken?

Appendix D

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What is the exit plan to support the person to leave seclusion?

Date next update due	
Update on continued seclusion (to be completed weekly)	
Written by: Job Title:	Date:

Briefing Report for Seclusion Incidents.dc

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.

Multi-disciplinary Team – a professional team including staff from a range of different professions.

Patient Care 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.

Advance 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 the8ir care and treatment. Advance 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 a 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.

Voluntary Confinement Plan – individual care plans should be developed with the services user, available to staff, kept up to date and should outline the criteria within the policy.