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Sussex Partnership
NHS Foundation Trust

SECLUSION & LONG TERM SEGREGATION POLICY AND PROCEDURE

(Following MHA Code of Practice 2015)

(Replaces Policy No. TPCL/023 V.5)

POLICY NUMBER	TPCL/023
POLICY VERSION	V.5.1
RATIFYING COMMITTEE	Professional Policy Forum
DATE RATIFIED	November 2019
DATE OF EQUALITY & HUMAN RIGHTS IMPACT ASSESSMENT (EHRIA)	November 2019
NEXT REVIEW DATE	November 2022
POLICY SPONSOR	Chief Nurse
POLICY AUTHOR	Nurse Consultants : Forensic Healthcare Service

EXECUTIVE SUMMARY:

Purpose:

- Purpose of seclusion and Long Term Segregation
- Conditions of the seclusion room
- Initiating seclusion and Long Term Segregation
- Reviewing and monitoring the patient whilst in Seclusion or Long Term Segregation
- Continuous observation the patient whilst in Seclusion or Long Term Segregation
- Record keeping
- Termination of the seclusion or Long Term Segregation episode

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1. OVERVIEW

Chapter 26 of the Department of Health's **Mental Health Act Code of Practice (2015)** is titled: 'Safe and therapeutic responses to disturbed behaviour'. This policy is based on the guidance given within the document regarding the use of restrictive interventions which includes seclusion and long-term segregation.

Sussex Partnership NHS Foundation Trust aims to provide safe, **positive and therapeutic environments** for patients who may have **behavioural disturbance**. The focus is on preventing behavioural disturbance, early recognition and de-escalation in keeping with the Trust's overall aim of reducing the need for restrictive interventions. As a last resort where restrictive interventions cannot be avoided they will always be used safely and respect human rights. The Trust is committed to ensuring that inpatient areas have robust and transparent governance processes that support, monitor, advise and report on the use of the restrictive practices of seclusion and long-term segregation

The Trust's Clinical Risk Assessment & Safety Planning Policy must be followed for all patients. This will be part of the information used in agreeing a positive behaviour support plan (incorporating the CPA, Care Programme Approach Policy) with each person using Trust services.

Where there is a significant risk of someone needing restriction, a **positive behaviour support plan** must be agreed with them as part of the care planning process 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**].** This will include prevention strategies:

- **Primary** – strategies that aim to improve the person's quality of life and meet their unique needs
- **Secondary** – recognition of the person's individual signs of impending behavioural disturbance and how to respond, including **de-escalation** and **enhanced observation and engagement**
- **Tertiary** – clear instruction on the **pre-planned use of restrictive interventions,** minimising distress and risk of harm. This can include **Advance Decisions to Refuse Treatment (ADRT) or Advanced Statements** (please see *Advance Decisions to Refuse Treatment (ADRT) & Advance Statements Policy).*
- Any restrictive intervention should be person-centred, values-based, and adhere to the principle of being the least restrictive option available to maintain safety.

There are many forms of restrictive interventions. They must never be used to deliberately inflict pain, punish, humiliate or threaten, or because of a shortage of staff.

Where a member of staff restricts a patient's liberty of movement or uses force the intervention must be:

- used for no longer than necessary to prevent harm to the person or others
- a proportionate response to that harm, and
- the least restrictive option.
- **take account of the service user's preferences,** if known and it is possible to do so
- take account of the service user's physical health, degree of frailty and developmental age

It must be used to:
- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and
- end or reduce significantly the danger to the patient or others.

These restrictive interventions include:
- Physical restraint
- Rapid tranquilisation
- Seclusion – the policy and procedures are set out first in this document
- Long-term segregation – the policy and procedures are set out second in this document.
- Mechanical restraint – this is primarily within the Forensic Healthcare Service and only for secure escorts and transfers of high risk patients.
- Deprivation of access to normal daytime clothing – the only time this may be appropriate is if the multi-disciplinary team risk assessment of the individual indicates a need for the person to wear tear-proof clothing

1.1 Definitions

Seclusion
This policy sets out the Trust's position on the use of seclusion and gives guidance for staff. The guidance applies to patients of all ages in hospitals provided by the Trust. It applies to all patients, regardless of whether or not they are detained under the Mental Health Act although ordinarily seclusion should only be used for detained patients (see the section on Legal Points).

Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.
Department of Health (2015) Mental Health Act (MHA) 1983: Code of Practice. p.300, para26.103:

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 must be afforded the procedural safeguards in the Code of Practice, as per this policy. Seclusion should only be undertaken in a room (or suite of rooms) that has been specifically designed for and designated as a seclusion facility and the Trust is committed to working towards ensuring that designated seclusion rooms meet the following standards:

- Allow for communication with the patient when the patient is in the room and the door is locked, for example, via an intercom.
- Include limited furnishings, which should include a bed, pillow, mattress and blanket or covering.
- Include strong clothing and bedding if required.
- Have no apparent safety hazards.
- Have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside).
- Have externally controlled lighting, including a main light and subdued lighting for night time.
- Have robust door(s) which open outwards.

- Have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature.
- Have no blind spots and alternate viewing panels should be available where required.
- Always have a clock visible to the patient from within the room
- Have access to toilet and washing facilities.

In summary, if a patient is kept away from peers and stopped from leaving, they are subject to seclusion, even if the door of the room is not locked. In such cases the rigorous requirements for supervising the patient and for managing and reviewing the process must still be adhered to.

Long Term Segregation
In contrast to seclusion, the Code of Practice defines **Long Term Segregation (LTS)** as "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"

The criteria for instigating such a regime should be that it has "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".

Place of safety
The Trust has five designated places of safety, plus 1 at Chalkhill for young persons, as defined by the MHA that are designed to receive a detained person temporarily under either section **135 or 136** of the MHA. However, in practice, due to the fact that a person received in a place of safety needs to be prevented from leaving until he or she has been assessed, the Trust seclusion policy will only apply when the **door to the place of safety has been locked.** When the person has been locked in the place of safety to prevent them from leaving, then the rigorous requirements for supervising the patient and for managing and reviewing the process must be adhered to. Please see the **Assessment of Persons under Sections 135 and 136 of the Mental Health Act 1983 Policy** for further information.

1.2 Legal points

The use of restrictive interventions must be compliant with the law, including the **Human Rights Act 1998,** and the **European Convention on Human Rights.** No restrictive intervention should be used unless it is necessary to do so in the circumstances and only if de-escalation has been tried, when practicable, and been unsuccessful.

The Code of Practice gives example of restrictions that may indicate there is a deprivation of an individual's right to liberty:

- Informal patients being prevented from leaving hospital
- Informal patients being told they will be detained if they do not comply with the requests of staff
- Informal patients being kept in circumstances that amount to seclusion without their consent

The MHA COP says “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”.

If emergency holding powers under the Mental Health Act have been used the relevant professionals must complete all necessary paperwork (e.g. Form H1 for medical staff using holding powers under section 5(2) of the MHA, and form H2 for nursing staff using holding powers to detain under section 5(4) of the MHA).

In all cases the circumstances that justify seclusion must be documented clearly and fully.

All staff must consider their statutory duties in regards to safeguarding children and vulnerable adults, if it is suspected an adult or child is at risk of abuse or neglect then safeguarding procedure’s should be followed and implemented. Please read this in conjunction with the Safeguarding Children’s Policy and Procedure and Adults Safeguarding Policy.

1.3 Authorising of seclusion

Seclusion can only be authorised by the following:

- the Nurse-in-Charge of a ward, or another Registered Nurse if it is not practicable to discuss with the Nurse-in-Charge at the time;
- a doctor;
- an Approved Clinician who is not a doctor.

1.4 Documenting episodes of seclusion and long-term segregation

All episodes of seclusion and long-term segregation can now be documented directly on Carenotes. The paperwork can be found under the patients “**Careplanning**” tab, and the following forms can be found by clicking “**Create New**”:

- Seclusion - Initial Record (this document also includes the initial MDT Review)
- Seclusion - Observation Recording Form
- Seclusion - Nursing 2 Hourly Review
- Seclusion - Medical Review
- Seclusion - Independent MDT Review
- Long-term Segregation - Prime Record
- Long-term Segregation - Amended Record
- Long-term Segregation - Hourly Record
- Long-term Segregation - Daily Review
- Long-term Segregation - Twice Weekly MDT Review
- Long-term Segregation - Monthly Review
- Long-term Segregation - Three Monthly Review

2.0 PROCESS

- Wherever practicable, other interventions should be attempted before the use of seclusion. When they have been tried, it should be documented what these other interventions were and that they have been considered or attempted. If not tried, the reason should be documented.
- The decision to seclude can only be made by a **Registered Nurse, a Doctor or an Approved Clinician who is not a Doctor.** This should be done in

consultation with the clinical team on duty, following a clinical assessment of the patient's presentation at that time. The assessment should have concluded that the patient poses an immediate and serious risk of harm to others. This should be documented by the person making the decision to seclude. When this is not a Doctor, within working hours, the Responsible Clinician and outside of working hours the duty Doctor should be informed immediately and this should be documented, including the time of contact.

- When seclusion is commenced it must be recorded on the **Seclusion Initial Record form** on Carenotes.
- If seclusion was not authorised by a Doctor there must be a medical review within one hour. This medical review may be undertaken by a junior doctor.
- Following any episode of acute behavioural disturbance that has led to the use of restrictive interventions a post incident review should be undertaken so that all involved parties, including patients have appropriate support and there is an opportunity for learning. It is important that patients are helped to understand what happened and why and to share their perspective of this. Any learning should be incorporated into their behaviour support plan. Patients with limited verbal communication skills may need additional support to participate in this.
- All episodes of seclusion commencing must be reported using the Web Incident Report form Report an incident
- Staff must follow the correct implementation process
- An **initial multi-disciplinary review of seclusion** must be carried out as soon as is practicable and also recorded on the **Seclusion Initial Record form** on Carenotes. The review should establish the care needs of the patient as quickly as possible
    - Care of a patient in seclusion
    - Monitoring and review
    - Record keeping and reporting
- Seclusion should be terminated as soon as it is considered safe to do so.

2.1 Patients' protected characteristics

Due regard must be given to the protected characteristics of patients (Equality Act 2010).

- **Children and young people –** further guidance in Section 5.
- People with dementia who are secluded may become further disorientated when kept apart from other people. This may further increase behavioural disturbance
- People who have physical disability and vulnerabilities may require extra care
- People who have emotional vulnerabilities may require extra care especially those who have previously been subject to violence or abuse
- The patient's gender identity, as per the Gender Reassignment policy
- Staff must be aware that there is national evidence to show that patients from black and minority ethnic communities are more likely to be secluded. This may be due to stereotyping. The risk presenting from each individual patient must be carefully assessed using the Clinical Risk Assessment and Safety Planning Policy.

3.0 DUTIES

3.1 Chief Nurse: responsible for bringing monitoring reports to the Quality Committee and, where required, the Board of Directors. Monitoring reports

must include plans for reducing the use of restrictive practices such as seclusion and long term segregation.

3.2 **Deputy Chief Nurse:** responsible for ensuring the Trust has up to date policies and procedures for the use of restrictive practices, including seclusion, that reflect national and international best practice. Also for ensuring policies and procedures are based on current legislation and guidance e.g. MHA Code of Practice, Care Quality Commission standards and NICE guidance.

3.3 **Doctors:** responsible for assessing, formulating, planning and reviewing care and treatment. Medical reviews provide the opportunity to evaluate and amend seclusion/long term segregation care plans including – physical and psychiatric health, medication prescribed and any adverse effects, observations required, risks to self and others and whether the arrangements for seclusion/segregation could be applied more flexibly or in a less restrictive manner.

3.4 **Matron:** responsible for monitoring the use of seclusion and long term segregation and learning lessons from their use. Their aim must be to reduce the use of restrictive practices, including seclusion.

3.5 **Ward Manager:** responsible for ensuring that all ward staff have a thorough understanding of restrictive practices including seclusion and long term segregation. Also that all ward staff are up to date with required training, and that if there is a designated seclusion room on their ward that it maintained to the required standards as set out in section 1.1 of this policy

3.6 **Nurse in charge:** responsible, when it is required, for the safe implementation of seclusion that respects the individual's dignity and human rights.

3.7 **Ward nursing staff:** must be familiar with this policy and understand the human rights implications of using restrictive interventions such as seclusion and long term segregation. They must also understand the psychological and physical risks associated with restrictive interventions and any physical interventions used to enforce seclusion which can have significant impacts on the patients recovery.. Their training in the prevention and management of violence and aggression and basic/immediate life support must be up to date. All Registered Nurses must have completed the Rapid Tranquilisation e-learning.

3.8 **Ward Pharmacist**: responsible for ensuring the medication is prescribed, administered and monitored within Trust standards as set out in the Medicine Code, Rapid Tranquillisation and high dose antipsychotics guidance. Where prescribing or administration of medication may require more specialist advice or complex decisions pharmacists should be involved as part of the MDT.

4.0 PROCEDURES

4.1 PRIMARY PREVENTION

Primary prevention strategies

The MHA Code of Practice (2015) and NICE Guidance (updated June 2017) "Restrictive interventions for managing violence and aggression in adults" provides helpful advice on primary preventive strategies:

The care environment:

- providing predictable access to preferred items and activities
- avoiding excessive levels of environmental stimulation
- organising environments to provide, for example quiet rooms, recreation rooms, single-sex areas and access to open spaces and fresh air
- giving each patient a defined personal space and a safe place to keep their possessions
- ensuring an appropriate number and mix of staff to meet patients' needs.
- ensuring that reasonable adjustments can be made to the care environment to support people whose needs are not routinely catered for, for example, those with sensory impairments
- avoiding demands associated with compliance with service-based routines and adherence to 'blanket rules'.

Engaging with patients and their families:

- ensuring that patients are able to meet visitors in private, convivial environments, as well as to maintain private communication by telephone, post and electronic media, respecting the wishes of patients and their visitors, subject to security considerations
- engaging patients, supporting them to make choices about their care and treatment and keeping them fully informed, and communicating in a manner that ensures the patient can understand what is happening and why
- engaging patients in all aspects of care and support planning
- involving patients in the identification of their own trigger factors and early warning signs of behavioural disturbance and in how staff should respond to them (known as advance statements)
- ensuring that meetings to discuss an individual's care occur in a format, location and at a time of day that promotes engagement of patients, families, carers and advocates
- with the patient's consent (if they have the capacity to give or refuse such consent) involving her or his nearest relative, family, carers, advocates and others who know the patient and their preferences in all aspects of care and treatment planning
- promptly informing patients, families, carers and advocates of any significant developments in relation to patients' care and treatment, wherever practicable and subject to each patient's wishes and confidentiality obligations.

Care and support:

- providing opportunities for patients to be involved in decisions about an activity and therapy programme that is relevant to their identified needs and includes evening and weekend activity
- delivering individualised patient-centred care plans which takes account of each patient's unique circumstances, their background, priorities, aspirations and preferences
- supporting patients to develop or learn new skills and abilities by which to better meet their own needs

- developing a therapeutic relationship between each patient and care workers, including a named worker or nurse identified as the patient's primary contact at the service
- providing training for staff in the management of behavioural disturbance, including alternatives to restrictive interventions, the attitude and values staff should have, and training in the implementation of models of care including positive behavioural support
- ensuring that patients' complaints procedures are accessible and available and that concerns are dealt with quickly and fairly.
- ensuring that physical and mental health needs are holistically assessed and the patient is supported to access the appropriate treatments
- developing alternative coping strategies in response to known predictors of behavioural disturbance.

4.2 SECONDARY PREVENTION

De-escalation

- De-escalation is a secondary preventative strategy. It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance.
- De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.
- Staff should liaise with individuals and those who know them well, and take into account clinical assessments, to identify individualised de-escalation approaches which should be recorded as secondary preventative strategies in the individual's **positive behaviour support plan** or equivalent e.g. My Support and Containment care plan within Forensic Healthcare. In some instances it may be feasible for families to contribute to de-escalation approaches, e.g. by speaking to their relative on the telephone
- Staff should ensure that they do not exacerbate behavioural disturbance, e.g. by dismissing genuine concerns or failing to act as agreed in response to requests, or through the individual experiencing unreasonable or repeated delays in having their needs met. Where such failures are unavoidable, every effort should be made to explain the circumstances of the failure to the individual and to involve them in any plans to redress the failure.

4.3 TERTIARY PREVENTION

Pre-planned tertiary prevention

Where an individual patient has been assessed as being at risk of requiring restriction a behaviour support plan must be agreed. As well as primary and secondary prevention strategies there must be a tertiary prevention plan to set out how restriction should be used if required.

Planned interventions should be individualised as much as possible and are likely to include: continuing de-escalation attempts, as far as practicable; summoning assistance; reducing stimuli or stressors as much as possible;

when restrictive interventions are considered necessary, using proportionate measures that aim to minimise distress and risk of harm to each patient.

The choice and nature of restrictive intervention will depend on various factors, but should be guided by:

- the patient's wishes and feelings, if known (e.g. by an advance statement)
- what is necessary to meet the needs of the individual patient based on a current assessment and their history
- the patient's age and any individual physical or emotional vulnerabilities that increase the risk of trauma arising from specific forms of restrictive intervention
- the patient's protected characteristics, especially in ensuring respect of privacy and dignity
- whether a particular form of restrictive intervention would be likely to cause the patient distress, humiliation or fear
- obligations to other patients affected by the behavioural disturbance
- responsibilities to protect other patients, visitors and staff
- the availability of resources in the care environment .

When a patient has a history of abuse, restrictive interventions of any nature can trigger responses to previous traumatic experiences. Responses may be extreme and may include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression. Patients' recorded wishes about restrictive interventions may be particularly useful for those with an identified history of trauma. Where possible and appropriate, patients' preferences in terms of the gender of staff carrying out such interventions should also be sought and respected.

Where risk assessment has identified a real risk of violence and aggression the behaviour support plan should advise on the most appropriate intervention. Positive behaviour support plans should form part of the patient's overall care package. Wherever practicable, the patient's views should be considered so that they can provide an advance statement about the method. Staff should be aware of such directives and attempt to adhere to them wherever possible.

However, staff will also have the right, and responsibility, to use alternative interventions if their clinical judgement is that the patient's interests, and/or the safety of others make this the most appropriate thing to do.

The Trust's policy on the Prevention and Management of Violence and Aggression must be followed and the least restrictive option used to seclude the patient when this is required. The use of prone restraint should be avoided as far as possible. This policy endorses the guidance in the Code of Practice for the Mental Health Act (2015 p.295, para26.70), which states that planned or intentional restraint of a patient in a prone position should be avoided on any surface, not just the floor, unless there are cogent reasons for doing so. I.e. the prone position should not be used deliberately unless there are compelling and convincing reasons to do so.

4.4 Dangerous Situations

Seclusion is a restrictive intervention and can only be used to take immediate control of a dangerous situation where there is a real risk of harm being

caused. The most common reasons for needing to consider the use of seclusion are:

- physical assault by a patient
- dangerous, threatening or destructive behaviour
- extreme and prolonged over-activity that is likely to lead to physical exhaustion
- attempts to escape or abscond (where the patient is detained under the Mental Health Act or deprived of their liberty under the MCA).

4.5 Defined Rooms

The following have rooms that have been designed and designated for the purpose of seclusion:

- Chichester Centre - Fir, Hazel, Pine Wards
- Hellingly Centre - Ash, Elm, Oak and Willow Wards
- Langley Green Hospital - Amber Ward
- Millview Hospital – Pavilion Ward
- Selden Centre
- Chalkhill

These rooms are specifically to be used for seclusion and **may not be used for other purposes**. They should be assessed regularly to ensure patients and staff will be as safe as possible when difficult circumstances arise and must comply with standards set out in advisory documents such as the MHA Code of Practice.

4.5.1 Restricting patients movements in response to dangerous situations

In dangerous situations (see section 4.4) it may be necessary to consider temporary restrictions upon patients for an immediate identified risk.

If the care team believe that the patient cannot be safely managed in any other way then they may react by placing a physical barrier between the patient and others such as closing and/or locking a door. In such rare occasions it will be permissible to confine the patient to a room or area for the duration in which the specific risk exists, and as this amounts to seclusion, the rigorous requirements for supervising the patient must be adhered to.

Members of staff who are present at the time of a violent or aggressive incident will have to make a decision about which intervention is required. Guidance will be provided on PMVA training programmes and updates/refreshers, and requires the care team to balance both the **immediate risk to others**, and the **safety needs of the patient**.

If this rare situation does occur then staff emergency response protocols must be initiated and consideration given to the guidance set out in both the physical restraint policy and rapid tranquilisation policy, e.g. the least restrictive physical intervention such as **seated de-escalation**, and/or the administering of **rapid tranquilisation**.

An incident form must be completed on the Trust Ulysses Safeguard system and an entry made in the patient records on Carenotes, detailing cogent reasoned justification. The site coordinator/Duty Senior Nurse must ensure that this incident form is completed.

If the care team believe that the immediate risk is too high to discontinue seclusion in a room or area not specifically designed for seclusion then a **purpose built seclusion room must be sought** as soon as practical. The decision to continue seclusion under these circumstances must be made by the Matron and Responsible Clinician during working hours, and the on-call Consultant and on-call Director outside of working hours.

4.6 Recording & Reporting an Episode of Seclusion

When seclusion is commenced **within office hours** the nurse-in-charge must inform the following people and document this contact and the time it took place:

- Responsible Clinician or the junior doctor for the ward or the junior doctor on call
- Ward Manager (if not already in attendance)
- Unit or Site coordinator/Duty Senior Nurse (where applicable)
- Matron

Outside office hours or on Bank Holidays the nurse-in-charge must inform the following people and document this contact and the time it took place:

- Junior doctor on call
- Senior person on site (e.g. Unit or Site coordinator/Duty Senior Nurse where applicable)

The time at which any of the above people attend the ward should also be documented.

When seclusion is commenced, record keeping should begin using the **Seclusion - Initial Record form** and the **Seclusion - Observation Recording Form** on Carenotes.

The principal entry in the patient's **Seclusion Initial Record form** should be made by the Nurse-in-charge and should be countersigned by a senior nurse or doctor. All parts MUST be completed until seclusion is discontinued.

The seclusion must also be recorded in:

- the patient's clinical notes, and
- on a Web Incident Form:

Web Incident Forms must detail;

- Start date and time
- End date and time
- Duration in seclusion
- Who authorised seclusion

Once in seclusion the patient must be observed at all times.

The patient should be within eyesight and sound of the observing member of staff and the **Seclusion - Observation Recording Form)** must be completed **at least every 15 minutes** and more often when there is significant information to report.

When seclusion is terminated, a summary should also be recorded in the notes, stating the time seclusion was discontinued and who was involved in the decision. The criteria upon which the decision was based should be

documented clearly, i.e. Evidence of positive change for the patient; the patient's ability to participate in the post-seclusion care plan

The arrangements for the initial period post-seclusion should also be documented clearly and should include at least 15 minute intermittent enhanced observation and engagement until reviewed by the clinical team.

As a guide, general observation would be inappropriate immediately after seclusion.

The patient must be offered the opportunity to discuss the seclusion and the events leading up to it and to explore what they and the care team can do in order to avoid the use of seclusion.

The information should be used to inform the positive behavioural support plan. If the patient refuses this should be recorded in their notes and offered at a later date.

4.7 Implementation of a Period of Seclusion

Implementation

- The seclusion room should be checked for readiness.
- When a patient is actually placed in a locked seclusion room at least one member of the staff who is present must be the same gender as the patient (or the gender the patient identifies with) and this should be documented.
- The patient must be informed of the reasons for seclusion.
- Consideration should be given to arrangements for access to toilet facilities balancing the need for risk management and dignity.
- The patient should be reassured that while they are in the seclusion room a member of staff will be monitoring them from outside the room at all times to ensure their safety.
- It should be explained to the patient that they can call for assistance if required.
- The allocated member of staff will keep the patient within sight and sound at all times.
- If **rapid tranquillisation** or PO PRN is used prior to seclusion, then the response and physical observations of the patient must be monitored in line with the Rapid Tranquillisation Policy.
- Any patient subject to restrictive physical interventions should be physically monitored continuously during that episode and at least every hour afterwards, for a period of 24 hours including when they are asleep. This check should include:
  - pulse
  - blood pressure
  - respiration
  - temperature fluid and food intake & output.
- If this is not practicable (e.g. due to either the distress or the hostility of the patient), their physical presentation must be documented as "non-contact" observations i.e. apparent breathing, level of alertness, movement, pallor and recorded on the NEWs/PEWs chart.
- If physical restraint is used to achieve seclusion this must be carried out in accordance with the Trust's Prevention & Management of Violence & Aggression (PMVA) policy and training. For each individual occasion the

least restrictive intervention should be used. **The prone position should not be used to seclude the patient unless there are compelling and convincing reasons to do so. If it is used this information must be recorded and the reasons explained.**

4.7.1 Self-harm

The Trust recognises that at times patients who may require seclusion also present with risks of self-harm. The Code of Practice 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".

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

4.7.2 Voluntary confinement

On occasion patients may wish to be voluntarily confined in a designated seclusion room as a means of self-regulating and managing their own risks to others.

When patients are deemed to have capacity, and are considered able to make decisions for themselves, an expressed wish to be confined in a seclusion room may be considered as long as the following criteria has been met:

- There is a **Positive Behavioural Support Plan** previously agreed that has been collaboratively formulated and signed by the patient and subsequently endorsed by the care team.
- That the nurse in charge of the ward is satisfied that the conditions of confinement/environment do not present undue risk to the patient or others.

If the above voluntary confinement criteria has been met, then the same rigorous safeguards and standards of observation and paperwork must be met as that of a standard episode of seclusion.

The overarching principle for voluntary confinement is that the patient has the ability to have their confinement or isolation ended **at a time of their choosing**. It is this distinction that separates voluntary confinement from the definition of seclusion, which is "the supervised confinement and isolation of a patient". Should a patient voluntarily confined as part of a crisis intervention plan not have their confinement curtailed on request for any reason then this amounts to seclusion and will be managed as such.

All instances of patients enacting voluntary confinement or isolation from their peer group will be recorded in the patient's Carenotes record and reported to the CDS seclusion monitoring group as voluntary confinement **and not** recorded as an episode of seclusion.

4.8 Searching a patient

- Prior to seclusion commencing in a designated seclusion room, the patient must be checked and searched to remove items which present a potential risk of harm. The search must be conducted by a member of staff of the

same gender as the patient (see Searching Patients and their Property policy).

- The removal of items should exclude items of jewellery of cultural significance to the patient (for example wedding rings and or religious jewellery). However, if assessment indicates that there is a clear and immediate risk of harm from these, relevant items should be removed. Their removal should be explained to the patient and documented fully in their notes.
- All removed items must be listed in the relevant section of the Seclusion - Initial Record form and placed in a secure storage area until they can be returned to the patient. The place of storage must also be documented on the same form at that time.
- As a guide, if the patient is subject to manual restraint by staff at the time, another member of staff should carefully check the patient's pockets, waistband and socks if worn.

4.9 Care of a patient in a seclusion room

- A seclusion care plan should set out how the individual's needs will be met and indicate what is required in order for seclusion to be terminated. As a guide, this care plan should include matters to do with: numbers of staff required to enter; safety; mental health; physical health if required; food, fluids and personal hygiene; medication; clothing and bedding; therapeutic activity; and details of any family, carer or advocacy contact that will be maintained.
- A suitably skilled staff member will be readily available **and have the patient within sight and sound at all times** throughout the period of seclusion.
- Suitably skilled means informed and aware of any risks associated with the patient's current health and presentation and what these may look like. For example, a patient who has received "as required medication" for the first time might be at risk of respiratory depression; a patient who has epilepsy may be at risk of seizures and falling to the floor.
- Within sight means being able to see the patient at all times.
- Within sound means being close enough to hear the patient's speech or other sounds at all times, in addition to being able to see the patient
- It is not permissible for the member of staff to undertake any activity that will reduce his or her observation of the patient, or ability to provide support. E.g. reading a newspaper.
- If **rapid tranquillisation** has been administered prior to seclusion, the vital signs of the patient should be monitored and recorded (using the NEWS/PEWS form) as per Rapid Tranquilisation Policy. If this is not possible (e.g. due to the patient refusing, due to the assessed risk of harm to staff or due to the likelihood of distress to the patient), the patient's physical presentation should be documented i.e. breathing, level of alertness, movement, pallor.
- If rapid tranquillisation has been administered prior or during seclusion where possible a post-incident review should take place as soon as possible and within 72 hours of an incident ending. Further details can be found in the rapid tranquillisation policy.
- The member of staff observing the patient in seclusion must have adequate call facilities available to them and be aware that, as a guide, they should not open the door when alone. If concerned about the patient they should summon assistance immediately.

- The interactions staff use to support secluded patients should be assessed and considered individually in each case. As a guide the allocated member of staff should make regular verbal contact with the patient, but this should not be done if the patient would prefer not to have this contact or is asleep. It would also be inappropriate if the patient is easily aroused and in need of a low-stimulus environment at the time. Any member of staff who is unsure should feel able to seek assistance from colleagues at such times, especially if they do not know the patient as well as others.
- Efforts should be made to ensure the patient remains oriented e.g. to location, date, time, mealtimes, staff on duty. Where practicable, a whiteboard with up-to-date information on it and a clock must always be visible to the patient from the seclusion room.
- Where the seclusion room door is closed and can be locked with a key, for added safety and security this must be done.
- If a key for the door is not routinely carried by ward staff, the handing over of the key from staff member to staff member must be carried out with care to ensure the key is always easily available (e.g. in case of emergency). In such cases ward managers should ensure a spare key is also available in an accessible part of the ward or unit.
- Staff should always bear in mind the individuality and dignity of each patient, including spiritual and cultural needs. There should be a record of how the patient's spiritual, cultural and religious beliefs were taken into account during the seclusion period.
- The individual patient's age, gender, gender identity, ethnicity, sexual orientation, religion and beliefs, pregnancy/maternity and marital/civil partnership status must be considered when planning and providing care while in seclusion. How these needs are met should be documented (Equality Act 2010).

4.9.1 Clothing

A patient in seclusion should always remain clothed. 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, 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.

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. The rationale for any decision to use strong clothing or bedding must be documented.

The use of positive behaviour support plans 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.

Blankets and clothing are available to order on Oracle under Thomas Kneale & Co. Ltd.

4.9.2 Visits

The Code of Practice recognises that for patients who are in seclusion or LTS 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

Official visitors should consult with the nurse in charge of the ward before visiting a secluded patient. In cases of concerns for the visitor, the nurse in charge of the ward should 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. This should also be documented in the patient's Carenotes.

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.

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.

If a visitor is not satisfied with the conditions under which the proposed visit will be facilitated then the nurse in charge should liaise with the senior nurse/manager on duty prior to the visit commencing. An entry should be made into the secluded patient's Carenotes detailing cogent reasons for the decision not to allow the visit to take place. The decision of the senior nurse/manager will be final.

4.10 Entering the seclusion room

- Any decision to enter the seclusion room must be made by the nurse-in-charge in consultation with colleagues. The decision must include what has to be undertaken, and the roles and responsibilities of each member of staff. When review/assessment of the seclusion is to take place, it must be clear who will lead the assessment. As per the Code of Practice for the MHA (2015 version; p.305, para 26.134), where practicable, 2 Registered Nurses should be involved in Nursing reviews and at least one of them should not have been involved directly in the decision to seclude this patient on this occasion. (NB. This does not mean that only two members of staff enter the room.)
- As a guide, a minimum of five members of staff will be required, all of whom should be up to date with their PMVA physical interventions training. Three staff to enter the room, one outside to support or assist with anything that is required, plus one to manage the door.
- At least one member of staff of the same gender as the patient (or the same gender the patient identifies with) must be present whenever staff are entering the seclusion room. This will ensure the privacy and dignity of the patient is maintained. However, this gender requirement will not apply in an emergency such as the patient becoming unwell and needing immediate assistance.
- Any intention to enter the seclusion room should be communicated to the patient.
- Where required, staff must follow the Prevention and Management of Violence and Aggression Policy.

4.11 Medication in seclusion.

- The prescribing of all medication must be on the official Trust prescription stationery and follow the Trust Standards as set out in the Medicines code. In most situations only medical staff have the authority to prescribe medicines for hospital inpatients, however if authorised by the Trust in certain situations non-medical prescribers may undertake this role.
- All medications must be reconciled to the medication prior to admission as per the Trust reconciliation protocol, any discrepancies should be investigated.
- If medication is taken into the seclusion room for administration, staff must ensure safe administration. If medication is refused or there is excess this must be removed from the seclusion room. This medication must be then stored or destroyed as per the medicines code.

4.12 Diet & personal hygiene

The team must ensure the basic needs of the patient are met.
The observing staff member must record the following on the **Seclusion – Observation recording form**"1) all food and fluid intake and
2) occasions when toilet and bathroom/washing facilities are used (or appear to be used).

These records are required so it is easy to monitor the meeting of the basic needs of patients, which is especially important when they cannot access some things freely themselves. The longer the seclusion period lasts the more important such records may become.

Key points are as follows:

- ensure that fluids are offered frequently and document this
- ensure that food is given at regular times and document this
- subject to risk assessment, ensure that only suitably safe utensils are provided and document such use and retrieval of items
- if assessment indicates that no utensils can be provided safely, ensure that the reasons for this are documented clearly in notes and that the food offered is easy to eat without them e.g. sandwiches. The situation should be re-assessed at each mealtime and decisions documented clearly in notes.
- ensure the patient has regular access to toilet and wash room facilities and document this. Bed pans and urine bottles should only be used when there is not a practical alternative. When the patient is using bathroom facilities, at least one staff member of the same gender (or the gender the patient identifies with) must be present and this should be documented

4.13 Fire

This section contains basic guidance on managing the situation if a fire occurs on a ward while a patient is locked in a seclusion room. The following points are based upon the assumption that the patient concerned is considered to pose a significant risk to other people at this time.

- Those present will have to use their discretion and professional judgement
- When members of the Fire Service are present, liaison should take place with them if possible
- If the fire is not affecting or threatening the seclusion room directly, in the first instance account for the ward's remaining patients and move them to a safe environment.

- Next, assess the requirements to move the secluded patient to a safe environment.
- The assessment will include consideration of whether or not physical restraint is necessary and the number of people that this will require.
- The safe environment used for the secluded patient may or may not be the same as that used for the other patients, as it will depend on the locations that are safe and available.
- Recent conflict or tensions between the secluded patient and any others should be taken into consideration as far as is practicable.
- Ensure that all patients remain contained, reassured and accounted for.

4.14 Monitoring and review of seclusion

Summary

- Patients detained in seclusion will be monitored within eyesight and sound of staff and reviewed regularly.
- Reviews must be taken as opportunities to assess the patient and the possibility of ending seclusion.
- Decisions to continue seclusion must be accompanied by clear documentation that justifies this decision.
- Similarly, decisions to terminate seclusion must be accompanied by clear documentation that justifies this decision. This can result from any of the required reviews or when the Nurse-in-Charge, in consultation with colleagues, feels that seclusion should end, they may consult the RC or duty Dr in person or on the telephone.
- When seclusion was not authorised by a Doctor, a medical review, which may be undertaken by a junior doctor, should take place within an hour of commencement.
- Nursing reviews (including 2 Registered Nurses) should take place every 2 hours throughout the period of seclusion and be recorded on the **Seclusion - Nursing 2 Hourly Review form** on Carenotes.
- Medical reviews, which may be undertaken by a junior doctor, should continue every 4 hours until the first internal multi-disciplinary review. After that they should be undertaken at least twice a day, one by the RC. All Medical reviews should be recorded on the **Seclusion - Medical Review form** on carenotes.
- It is permissible to make different arrangements for medical reviews when patients are asleep (especially at night) in order to avoid waking them but this must be recorded in a seclusion care plan. In such cases, Nursing reviews should still take place from outside the room in order to monitor the patient's wellbeing.
- The first internal multi-disciplinary review should take place as soon as practicable.
- Following the first internal multi-disciplinary review, if seclusion is to continue medical reviews should then take place at least twice a day, and at least one of these should be undertaken by the Responsible Clinician, although others may be undertaken by a junior doctor. After 8 hours of seclusion (or 12 hours intermittently within a 48-hour period), an Independent Multi-disciplinary Team review should take place and this must be recorded on the **Seclusion - Independent MDT Review form** on Carenotes.
- Termination of seclusion must include an initial post-seclusion care plan which the patient has agreed to. At least initially, the subsequent observation and engagement used for the patient should be at least at the intermittent level with observation/ contact every 15 minutes.

- Ordinarily it is safe and appropriate to enter the seclusion room to undertake a review. If ever there is considered to be too great a risk of harm from the patient if staff enter the room, it will be reasonable to carry out a review from outside the room with the door locked. In such cases, the attempts to speak to and assess the patient must be witnessed by not only the lead reviewer/assessor but at least one more registered professional. Contents of discussions must be documented afterwards. If it is not considered sufficiently safe to enter the room it follows that the review will not conclude that the period of seclusion can be terminated on that occasion but documentation must be clear and objective.

Procedure

- **Seclusion Observation** An allocated member of staff must observe the patient by keeping her/him 'within eyesight' at all times and making a written record at least every 15 minutes on to the **Seclusion - Observation Recording Form** on Carenotes (The purpose of this observation is to monitor the mental health and behaviour, and the physical health of the patient. This form should also be used to monitor food and fluid intake and use of toilet/bathroom facilities.
- **Handover** Any person taking over responsibility for observing the patient in seclusion must have a full handover, including details of the incident that resulted in the need for seclusion and subsequent reviews.
- If seclusion was commenced by a Registered Nurse **the first medical review** should be **within one hour**, and may be undertaken by a junior doctor. **Nursing Reviews** Each secluded patient will be formally reviewed every two hours. As far as practicable, each nursing review will involve two Registered Nurses (with colleagues supporting when they enter the room). To ensure impartiality, as far as practicable, at least one of the Registered Nurses should not have been involved directly in the decision to seclude. The review will be recorded on the **Seclusion - Nursing 2 Hourly Review form on Carenotes.** If there are concerns about the patient's condition, this should be immediately brought to the attention of the patient's Responsible Clinician or the duty doctor. Nursing reviews should continue every 2 hours.
- **Medical Review** – Initially the secluded patient will be formally reviewed **every 4 hours** by a Doctor (with Nursing staff), including evenings weekends and bank holidays. If it is considered better for the patient to have night-time reviews omitted when they are asleep, this should be documented in a seclusion care plan so any apparent gaps are explained. Each review must be recorded on the **Seclusion - Medical Review form on Carenotes**. Continuing 4-hourly reviews must be take place until the first internal MDT review has occurred. Following the internal MDT review (see below) there must be **at least two daily medical reviews**, one of which must be undertaken by the patient's **Responsible Clinician**. Two medical reviews per day is a minimum so it can and should be increased if the patient is considered to require more frequent medical review. **Initial MDT review** – This should be held as soon as practicable and recorded on the **Seclusion - Initial Record form** on carenotes. Membership should include the Responsible Clinician, or an approved clinician, the senior nurse on the ward and staff from other disciplines who would normally be involved in MDT reviews of patients. At weekends and overnight the initial MDT review may be limited to medical and nursing staff, in which case the Unit or Site Coordinator should also be involved (where applicable).

- Further MDT reviews should take place once in every 24 hour period of continuous seclusion.
- **Independent MDT review** – This must occur for a patient who has been secluded for more than **8 consecutive hours or 12 hours within a 48 hour period.** A multi-disciplinary review must be completed by a Doctor, who is an Approved Clinician (AC) and not involved in the patient's care, a Senior Nurse (Band 6 or above) and other professionals who were not involved in the incident which led to the seclusion, and an Independent Mental Health Advocate (IMHA) in cases where the patient has one. When an independent MDT review takes place, wherever possible staff involved in the original seclusion will be consulted. The independent MDT review must be recorded on the appropriate form

  The Code of Practice for the Mental Health Act (2015 version) does not specify the membership of the MDT Review at weekends and overnight. **When required at such times, the Trust therefore requires the review to be carried out by the on-call Approved Clinician, a Registered Nurse, and a senior nurse who was not involved in the incident which led to seclusion** (e.g. Unit or Site coordinator/Duty Senior Nurse where applicable).

- When seclusion has been used for a prolonged period, and the local environment can facilitate it, a patient in seclusion may have planned and supervised access to secure garden areas for fresh air or exercise. A risk assessment must precede any such decision and the subsequent plan should include agreement in advance with the patient on how long will be spent there and how many staff will be in attendance. Contingency arrangements must also be in place. At these times, use of a secure garden for access to fresh air will not constitute termination of seclusion. Records must state clearly what time this access commenced and ended.

4.15 Terminating seclusion

Seclusion can only be terminated by the following:

- the MDT at any of the required reviews; or
- When the Nurse-in-Charge, in consultation with colleagues, feels that seclusion should end, they may consult the RC or duty Dr in person or on the telephone. (Both parties should make clear records of discussions). If there is disagreement that cannot be resolved initially, the ending of seclusion should be postponed until agreement is reached (see below).

When patients are reviewed in any clinical context there may sometimes be disagreement among the staff team about what has happened and/or the most appropriate next step. Disagreement can be an inevitable and healthy part of professional clinical practice and can assist learning and the formulation of rationales for practice. When there is disagreement about the conclusion of a seclusion review, this should be used to progress discussions further and this can itself often lead to compromise and agreement. Where disagreement continues, senior members of staff should be invited to contribute wherever practicable.

Seclusion can of course be considered to be at the controlling end of a *restriction/free movement* continuum. If there are continuing concerns about the risk posed by a patient whose seclusion has been reviewed, but the team

agree that such positive risk taking is appropriate and professionally defensible, subsequent plans should incorporate graded reductions in restriction rather than leaping from one end of the continuum to the other. For example, initially post-seclusion the patient might be allocated two members of staff and be required to remain in an agreed area only. Much will depend on the environment and other resources as well as the patient's willingness to collaborate, and in some cases the initial plan may even match the new definition of seclusion (re: being kept away from other patients and being prevented from leaving a set area). If it does, review arrangements should continue as per seclusion for as long as such significant restriction applies. However, with regular reviews, ongoing assessment and intense staff support many patients progress beyond such restrictions and towards greater freedom and normality.

Although the Code of Practice (par26.111) appears to sanction allowing patients in seclusion to come onto ward areas as a trial and then return to seclusion when there have been no concerns, in the services run by this Trust it is not appropriate for this to happen. If a professional assessment indicated that the trial period in such an area was reasonable and professionally defensible, then the fact that there were no concerns should be seen as at least an initial confirmation that it was appropriate to terminate seclusion. Any later concerns that lead to seclusion will mean a new period of seclusion has commenced.

After a period of seclusion has ended, the initial level of observation and engagement used to continue the patient's care should be at least the 15 minute 'Intermittent' level. The General level should not be used until a later assessment by the MDT has concluded that this would be appropriate.

4.16 Patient engagement and experience

All patients should have a positive behavioural support plan and be encouraged to participate in the development of such plans if capable and willing to do so.

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

A copy of this policy should be readily available to patients on request and whenever possible patients should be encouraged to participate in the development of the seclusion care plan. This should be evidenced in the patient's Carenotes record.

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

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

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 Carenotes record, and their positive behaviour and support plan should then be reviewed and updated.

4.16.1 Complaints

The safeguarding lead for the care delivery service should be informed whenever a patient makes a complaint about the use of seclusion or long-term segregation, and a referral should be made to the local authority safeguarding team.

4.16.2 Appeals

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

5.0 Children & Young People

The MHA Code of Practice (2015; p.293, para 26.57) advises that seclusion can be a traumatic experience for any patient but can have particularly adverse implications for the emotional development of a child or young person. This should be taken into consideration in any decision to seclude a child or young person.

Careful assessment of the potential effects of seclusion is required and should be undertaken by a trained child and adolescent clinician. This is especially so for those children and adolescents with histories of trauma and abuse, where other strategies to de-escalate behaviours may be more appropriate than the use of seclusion.

Further guidance can be found within NICE Pathways Managing violence and aggression in children and young people" updated June 2017 and the recently published guidance for children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings Reducing the need for restraint and restrictive intervention (Department of Health and Social Care, 2019)

5.1 Seclusion at Chalkhill - CAMHS In-Patient Services

NICE guidelines recommend that those under 18 should **not** be placed in a locked room. In the event that seclusion is assessed as the only safe management option, due to the young person posing a risk to others, then the Mental Health Act - Code of Practice should be followed closely.

Careful assessment of the potential effects of seclusion is required and should be undertaken by a trained child and adolescent clinician (generally a Nurse or Doctor). This is especially so for those children and adolescents with histories of trauma and abuse, where other strategies to de-escalate behaviours may be more appropriate than the use of seclusion. If it is felt that a young person is at risk of seclusion then a behaviour support plan should be completed as a way of making any seclusion as safe and damage limiting as possible. This plan should include:

- Strategies to improve young person's quality of life
- Recognition of young person's individual signs of impending behavioural disturbance and how to respond

- Clear instruction on pre-planned use of restrictive interventions. This can include advance directives.

5.2 Mental Health Act Code of Practice CAMHS

26.53 Service providers should ensure that staff involved in the care of children and young people who exhibit behavioural disturbance are able to employ a variety of skills and strategies that enable them to provide appropriate help and support (please refer to Chapter 19 of Code of Practice). In most cases restrictive interventions will only be used if they form part of the positive behaviour support plan (or equivalent) and have therefore been developed with input from the child or young person and their family.

26.54 Staff should always ensure that restrictive interventions are used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.

26.56 The size and physical vulnerability of children and young people should be taken into account when considering physical restraint. Physical restraint should be used with caution when it involves children and young people because in most cases their musculoskeletal systems are immature which elevates the risk of injury.

26.105 Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward.

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

26.111 In order to ensure that seclusion measures have a minimal impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient's circumstances. Where seclusion is used for prolonged periods (over 24 hours) then subject to suitable risk assessments, flexibility may include allowing patients to receive visitors and facilitating brief periods of access to secure outside areas. The possibility of facilitating such flexibility should be considered during any review of the ongoing need for seclusion. Particularly with prolonged seclusion, it can be difficult to judge when the need for seclusion has ended. This flexibility can provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without terminating the seclusion episode

26.61 Staff having care of children and young people should be aware that under section 3(5) of the Children Act 1989 they may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'. Whether an intervention is reasonable or not will depend, among other things, upon the urgency and gravity of what is required. This might allow action to be taken to prevent a child from harming him/herself, however it would not allow restrictive interventions that are not proportionate and would not authorise actions that amounted to a deprivation of liberty.

6.0 Time out

The behavioural technique referred to as 'time out' should be recognised as quite different from seclusion. Seclusion is essentially about the maintenance of safety in in-patient settings that have seclusion rooms, and often involves the removal of a patient to a seclusion room because it is necessary to prevent harm to other people.

Originally short for 'time out from positive reinforcement', *time out* is concerned with changing an individual's behaviour by reducing the reinforcement of certain actions/ behaviours and promoting the reinforcement of certain others. It does not involve locking a patient alone in a room.

Time out should only be utilised as part of an agreed and professionally developed behaviour modification programme as part of a positive behavioural support plan. Where used with children within the Trust's services, it should be guided by policy and documented clearly as part of a positive behaviour support plan, and reviewed as part of the local Reducing Restrictive Interventions group.

7.0 Long-term Segregation

Introduction

This policy also addresses long-term segregation and is guided by the Department of Health's *Code of Practice for the Mental Health Act* (MHA) (paras 26.150-160).

For most patients who are placed in seclusion the experience will last for a short period only. However, in a small number of cases the risks posed by some individuals remain at a high level for longer periods and a longer term of restriction may be necessary and justifiable in order to maintain safety. The MHA Code of Practice describes long-term segregation as:

"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/unit on a long-term basis" (DoH, 2015; para 26.150, p.308).

The Code of Practice also makes the following points:

- Long-term segregation is only to be used where it has been determined that a short period of seclusion, combined with other treatment, would not be sufficient to reduce the risk of harm to others
- Where long-term segregation is being considered the views of the person's family and carers should be sought and taken into account, when this is appropriate
- The multi-disciplinary review of the long-term segregation should include an Independent Mental Health Advocate (IMHA) where the patient has one
- The environment used for long-term segregation should, as far as risk considerations allow, be homely, personalised and with access to bathroom, bedroom and lounge area. Patients should also be able to access secure outdoor areas and a range of activities of interest and relevance to the person.

- Patients should not be isolated from contact with staff and when long-term segregation is applied the patient should be supported through enhanced observation. (As a guide for this policy, this should be 'within eyesight' observation and engagement.)

Patients for whom long-term segregation is used must be legally detained in the unit concerned and the environment used must be capable of meeting the conditions the Code of Practice stipulates (in para26.151) i.e. that facilities should be as homely as possible and, as a minimum, allow access to a bathroom, bedroom and lounge area.

The use of long term segregation will primarily, but not exclusively, be within forensic healthcare services due to the nature and presentation of the patients it provides care for. However, the Trust recognises that on rare occasions, and for cogent clinical reasons, a patient within an inpatient area other than forensic health care services 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.

Following a suitable assessment that concludes that it is appropriate and justifiable, the precise arrangements for any occasion of long-term segregation will be dependent upon the local ward environment and the circumstances (i.e. the patient's presentation and who is at risk). These details must be made explicit in the **Long-term Segregation - Prime Record form** on Carenotes, in the patient's care plan, and in personal explanation to them. Similarly, all members of staff and any others who come to work there, even if only temporarily, must be made aware of the details so they do not inadvertently compromise safety by working in ways which are inconsistent, for example. Indeed, consistency of practice is a vital matter in the implementation of long-term segregation. In all cases where Long Term Segregation is instigated an incident form must be completed on Ulysses.

7.1 Plan of care

The plan of care for long-term segregation must:

- state the reasons why long-term segregation is required
- aim to end long-term segregation
- cite the actions and interventions of staff who will be with the patient
- state what is required of the patient in order for termination of it to take place (e.g. evidence of positive change and what form this will take). This should be communicated to the patient.
- include the requirement for detailed written entries by allocated staff every hour.

As far as possible, the plans should include identifying and allowing the patient access to use of secure garden/outdoor area, albeit at agreed times only, and to low-stimulus, meaningful activities. An Occupational Therapist should be asked to contribute to the planning of these and any other activities.

Psychological interventions will also continue to take place by the ward Psychologist in line with local protocols (e.g. the FHS psychological interventions for Long Term Segregation patient's protocol).

7.2 Commencing long-term segregation

A risk assessment must be undertaken before long-term segregation can be implemented. This assessment is in order to identify whether or not it would be clinically appropriate and professionally defensible. It must also consider practical matters such as:

- the safety of supporting staff;
- how many of them would be required to maintain safety and manage the risks; and
- the safety of all others who may otherwise come into contact with the patient.

This assessment should be carried out by a minimum of a Doctor, and two registered professionals. As far as is practicable, the Dr should be the patient's RC (or the person covering this role), and one of the two registered professionals should be from another ward/unit. Members of staff on duty on the host ward should also be consulted when possible. The **Long-term Segregation - Prime Record form** on Carenotes must be completed. If the details of the long-term segregation are later changed a **Long-term Segregation - Amended Record** form must be completed on Carenotes. The patient and all staff involved in the patient's care must be briefed on the changes.

Those who undertake the assessment should be aware that their clinical assessments, reasoning and rationales for utilising this particular restriction of the patient will be open to clinical peer review and possibly even further scrutiny in order to maintain high standards of practice and ensure that the least restrictive practices are used in each patient's care and management. The completed Appendices and entries in clinical notes must provide clear explanations for decisions and clear details of plans.

7.3 Possible arrangements for long-term segregation

As mentioned, the precise arrangements will depend on the result of a thorough and documented risk assessment by clinicians involved. However, three guiding options are cited below. If any are agreed for use the patient should have the details explained to them and these details should include information about the restrictions on movement and contact with others, the clinical input that will be available from professionals, and the review arrangements. If the patient was previously in seclusion and it is proposed that they will remain in the room with the door locked as part of a long-term segregation arrangement, the differences in review arrangements should be made clear. (Seclusion would require at least 2 reviews per day plus 2-hourly Nursing reviews; Long-term Segregation requires at least one daily review led by an AC, but not Nursing reviews.)

This policy's three guiding options for long-term segregation are outlined below. It should be noted that options 1 and 2 **must** have the agreement of the patient in advance of either of them commencing. The agreement of the patient for option 3 is also desirable, and the matter should be discussed with her or him in advance.

1. Use of the patient's own bedroom plus set areas of the ward, albeit at agreed times only if required.
In this case, the least restrictive of the 3 long-term segregation options, if assessment indicates it is appropriate, at least one member of staff should be

allocated to the patient to undertake 'within eyesight' observation and engagement and maintain the **Long-term Segregation - Hourly Record form** on Carenotes. If the patient is hostile to one or more people specifically (whether staff, patients or visitors), it is essential that arrangements are sufficiently clear and robust to ensure access to them is not possible.

In sum, for this policy, these arrangements would be permissible if assessment indicated the following:

- it was considered safe enough for staff to be relatively close to the patient in these circumstances; and
- it was considered safe enough and defensible for the patient to be restricted to an area from which they could potentially try to get past staff and gain access to others (in a nearby corridor, for example).

If neither applies, this would not be the most suitable option.

2. Use of a seclusion suite with the seclusion room door unlocked and the patient able to access adjoining lounge facilities, albeit at agreed times only if required.
In this case at least two members of staff should be allocated to the patient to undertake 'within eyesight' observation and engagement and maintain the **Long-term Segregation - Hourly Record form** on Carenotes.
In sum, for this policy, these arrangements would be permissible if assessment indicated the following:

- it was considered safe enough for staff to be fairly close to (and potentially accessible to) the patient in these more isolated circumstances; and
- it was considered necessary and defensible to ensure the patient could not gain any access to people other than the allocated members of staff.

If neither apply this would not be the most suitable option.
When it is considered suitable, at least 2 members of staff must be allocated to the patient in these circumstances because care will be provided in an isolated area.

3. Use of a seclusion room with the door locked and the patient only able to access adjoining lounge facilities at agreed times and with contingency arrangements in place.

When the seclusion room door is locked but this is as part of agreed Long-term Segregation arrangements, one member of staff must be allocated to the patient to maintain the **Long-term Segregation - Hourly Record form**, rather than the **Seclusion - Observation Recording Form**. However, on occasions when adjoining lounge facilities are used by the patient there must be at least three members of staff present.

In sum, for this policy, use of a locked seclusion room would be permissible for Long-term Segregation if, after 3 days/72 hours (please see comment in paragraph below for further clarification) or more of continuous seclusion, a multi-disciplinary review concluded that:

- the risk of harm to others remained real and significant; and
- it was not considered safe enough for staff to be close to and accessible to the patient in these circumstances; and
- it would not be defensible or appropriate to allow the patient to have contact with other people at this time; but

- it would be defensible and appropriate to transfer arrangements to those of long-term segregation.

It is **not** the case that episodes of seclusion should automatically become long-term segregation after 72 hours, with the differing review arrangements etc. Rather, it is the case that seclusion cannot be altered to this type of long-term segregation arrangement (with the locked seclusion room) until 72 hours or more of seclusion have lapsed and the multi-disciplinary team (MDT) assessment concludes that the risk to others posed by the patient is not decreasing and there could be benefits for the patient in transferring arrangements to those of long-term segregation within a locked seclusion room.

In any case of long-term segregation a representative from the responsible commissioning authority should either be invited in advance to join that multi-disciplinary review or be contacted after the reviewing professionals have come to this conclusion. However, transfer to long-term segregation arrangements could not take place until the representative has heard the details and rationale of the clinical team and confirmed agreement. The responsible clinician should lead liaison with the representative.

If options 1 or 2 were used (use of bedroom & set areas; or use of seclusion suite with seclusion door unlocked) but it became necessary to detain the patient in a locked seclusion room in order to maintain safety, this would constitute the end of long-term segregation and the commencement of seclusion, and the Trust's Seclusion policy, including more frequent reviews, would then have to be adhered to in full.

The maximum amount of time staff should be allocated to work with a patient subject to long-term segregation should be 2 hours.

7.4 Recording and reviewing long-term segregation

When long-term segregation is in use, observation and engagement must be at the 'within eyesight' level or 'within arm's length' level if considered more appropriate. The 'intermittent' level of observation would not be satisfactory.

Members of staff allocated to work with and support patients subject to long-term segregation must make written records at least every hour on the **Long-term Segregation - Hourly Record form** on Carenotes.

Members of staff can be allocated to undertake this role for up to 2 hours at a time.

If, following a review, Long-term Segregation is to continue but under different arrangements, the Long-term Segregation - Amended Record form must be completed on carenotes.

7.4.1 Long-term Segregation - Daily Review

As well as the above arrangements and hourly recording, review of agreed long term segregation must take place at least once per day. It should be led by an approved clinician and involve ward-based staff plus at least one qualified registered professional from another ward/unit. Rationales for decisions (whether to end or to continue it) must be documented clearly and explained to the patient. Any justification for continuing long-term segregation must include identification of a

continued significant risk to other people. The **Long-term Segregation - Daily Review form** on Carenotes must be completed.

7.4.2 Long-term Segregation - Once Weekly MDT Review

Review by the patient's multi-disciplinary team must take place at least once a week as stated in the MHA Code of Practice.

When these MDT reviews take place they should include the patient's Responsible Clinician, or a nominated person to cover this position, an IMHA, ward-based staff plus at least one qualified , registered professional from another ward/unit. Rationales for decisions (whether to end or to continue it) must be documented clearly and explained to the patient. Any justification for continuing long-term segregation must include identification of a continued significant risk to other people. The responsible commissioning authority must be informed of the outcome of every MDT review. **The Long-term Segregation - Once Weekly MDT Review form** on carenotes must be completed.

7.4.3 Long-term Segregation - Monthly Review

If long-term segregation remains in use for a month, two senior clinicians from elsewhere in the Trust (ie. not from the core service and not involved in the case) should be asked to join an MDT review so that, as a minimum, independent senior clinicians can contribute to the review every month. **The Long-term Segregation - Monthly Review form** on Carenotes must be completed.

7.4.4 Long-term Segregation - Three Monthly Review

Where long term segregation continues for three months or longer, as well as the above measures regular three-monthly reviews of the patient's circumstances and care should be undertaken by an external hospital. This should include discussions with the patient's IMHA (where appropriate) and commissioner. **The Long-term Segregation - Three Monthly Review form on Carenotes must be completed**. The patient's RC and the ward manager should coordinate this.

After a period of long-term segregation has ended and restriction decreased, the initial level of *Enhanced Observation and Engagement* used to continue the patient's care should be at least 15 minutes Enhanced level. The General level should not be used until assessment by the MDT has concluded and documented that this is appropriate and defensible with regard to clinical risk management.

8.0 Training

All staff working on wards where Seclusion or Long Term Segregation must familiarise themselves with the contents of this Policy as part of their induction programme.

All staff involved in using planned restrictive physical interventions must have up to date compliance with Prevention and Management of Violence and Aggression (PMVA) training.

As part of PMVA training course (5 day and update) members of staff are trained to always use least restrictive options, promote the use of personal behaviour support plans and ongoing de-escalation.

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The PMVA training also demonstrates how to safely escort a person into Seclusion without making any physical contact.

The PMVA team demonstrate a small number of options for restrictive physical interventions on occasions when they leave a patient in a seclusion room just before the door is closed. One of these options should be used if the patient is secluded and restrictive interventions are being used a last resort.

Members of staff are also trained in procedures for entering locked seclusion rooms, managing risks and reviewing patients. These procedures do not involve routine manual restraint of the person in seclusion. They do involve positioning of the staff in readiness for the team to undertake restraint if it becomes necessary to do so in order to maintain safety.

9.0 Resources

Department of Health **(2015) Mental Health Act 1983 Code of Practice: TSO**

National Institute for Clinical Excellence. 2005. *Clinical Guideline 25 Violence – the short-term management of disturbed/violent behaviour in in- patient psychiatric settings and emergency departments.* London: National Institute for Clinical Excellence. (Updated for May 2015.) http://www.nice.org.uk/guidance/gid-cgwave0619/resources/violence-and-aggression-update-draft-full-guideline2

Restrictive interventions for managing violence and aggression in adults. NICE Pathways, see: http://pathways.nice.org.uk/pathways/violence-and-aggression
Pathway last updated: 28 June 2017

Managing violence and aggression in children and young people. NICE Pathways, see: http://pathways.nice.org.uk/pathways/violence-and-aggression
Pathway last updated: 28 June 2017

Centre for Mental Health and Mental Health Network, NHS Confederation (2014) **Risk, Safety and Recovery**. Implementing Recovery Through Organisational Change (IMROC) –ImROC Briefing - Risk Safety and Recovery.pdf

Department of Health (2014) **Positive and Proactive Care: reducing the need for restrictive interventions.**
https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions

Department of Health, National Risk Management Programme (2007) **Best Practice in Managing Risk**: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services Best Practice in Managing Risk.pdf

Department of Health and Social Care (2019) **Reducing the need for Restrictive Interventions**: Children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812435/reducing-the-need-for-restraint-and-restrictive-

intervention.pdf?_ga=2.58060714.1828531418.1566823639-640781401.1563445916

10.0 Cross Reference

Sussex Partnership NHS Foundation Trust Policies:

- Advance Decisions to Refuse Treatment (ADRT) & Advance Statements Policy
- PMVA - Prevention & Management of Violence & Aggression
- Searching Patients and their property Policy
- Rapid Tranquilisation Policy
- Medicine Code
- Clinical Risk Assessment and Safety Planning Policy
- Care Programme Approach Policy
- Assessment of Persons under Sections 135 and 136 of the Mental Health Act 1983 Policy
- Section 5 (holding powers) Policy
- Resuscitation and Anaphylaxis Policy

11.0 Governance

11.1 Seclusion and LTS monitoring arrangements

Each care delivery service will have a robust seclusion and Long term Segregation monitoring process in order to ensure that their governance arrangements “enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive interventions”.[Chapter 26.5].

This process will be overseen by a Reducing Restrictive Interventions group, whose membership will be determined by the care delivery service but will include the Lead Nurse/Nurse Consultant.

The role of this group will be to

- Ensure all patients have a positive behavioural support plan when clinically indicated (all forensic and PICU patients should have one)
- Develop and monitor the use of a service specific post seclusion debrief tool
- Monitor formal debriefs for staff involved when a patient is secluded
- Monitor the adherence of seclusion to the Code of Practice and any departures from such
- Receive and analyse data relating to, and monitor overall trends in, the use of seclusion
- Monitor and report on other areas of restrictive practice as determined appropriate by each care delivery service
- Submit reports to clinical teams and leadership teams as required
- Review documentation for the collection of information about the use of seclusion and alternative management strategies
- Consider any staff training and education issues and make recommendations to the leadership team
- 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 in their CDS and wider Trust
- To report 6-monthly to the Trust Reducing Restrictive Interventions group

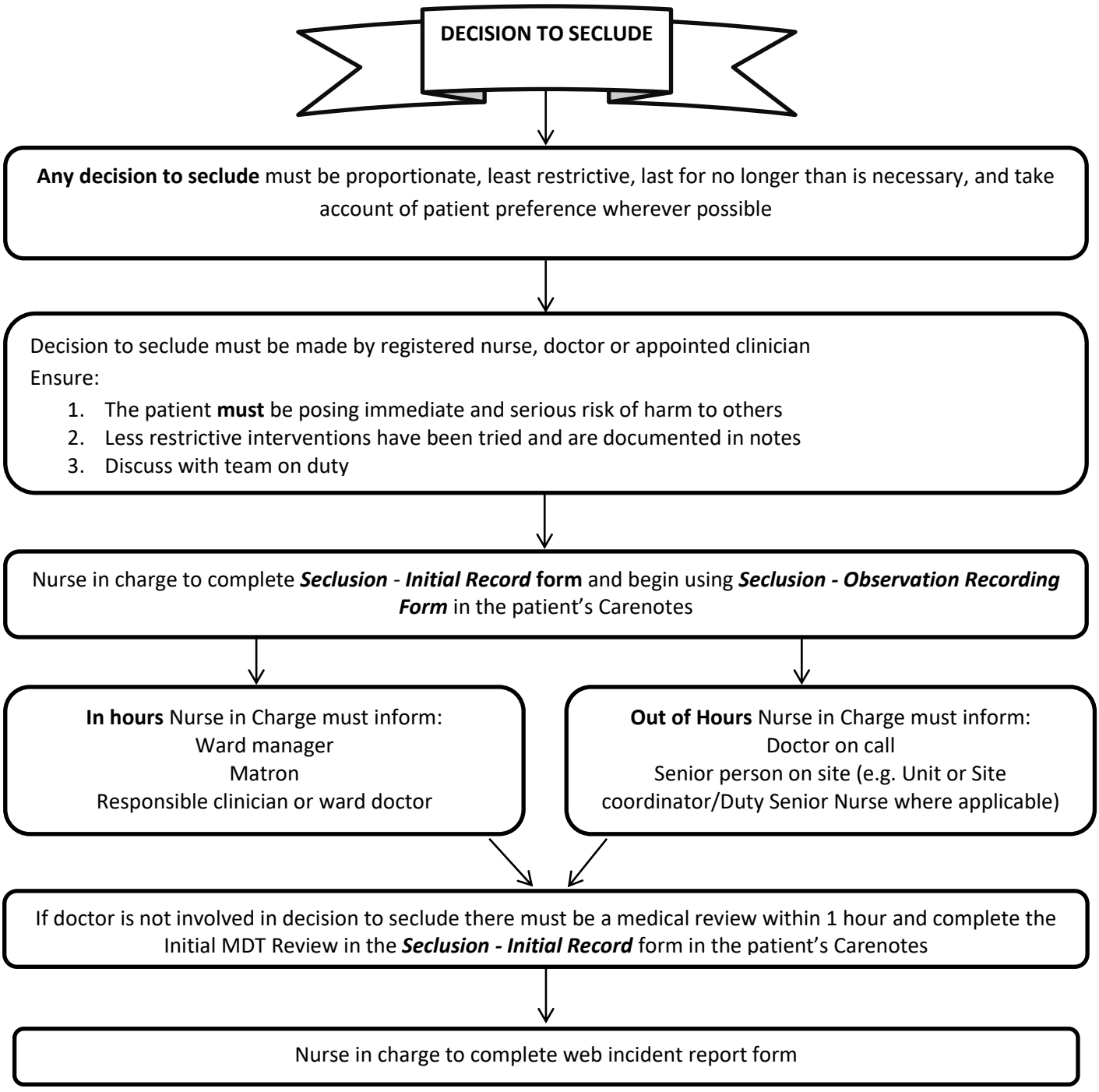
The Care Quality Commission will have a standing invitation to attend the Trust Reducing Restrictive Interventions group.

Incidents of Seclusion and Long Term Segregation will be reported in the quarterly Quality and Patient Safety report and monitored via the Safety Committee.

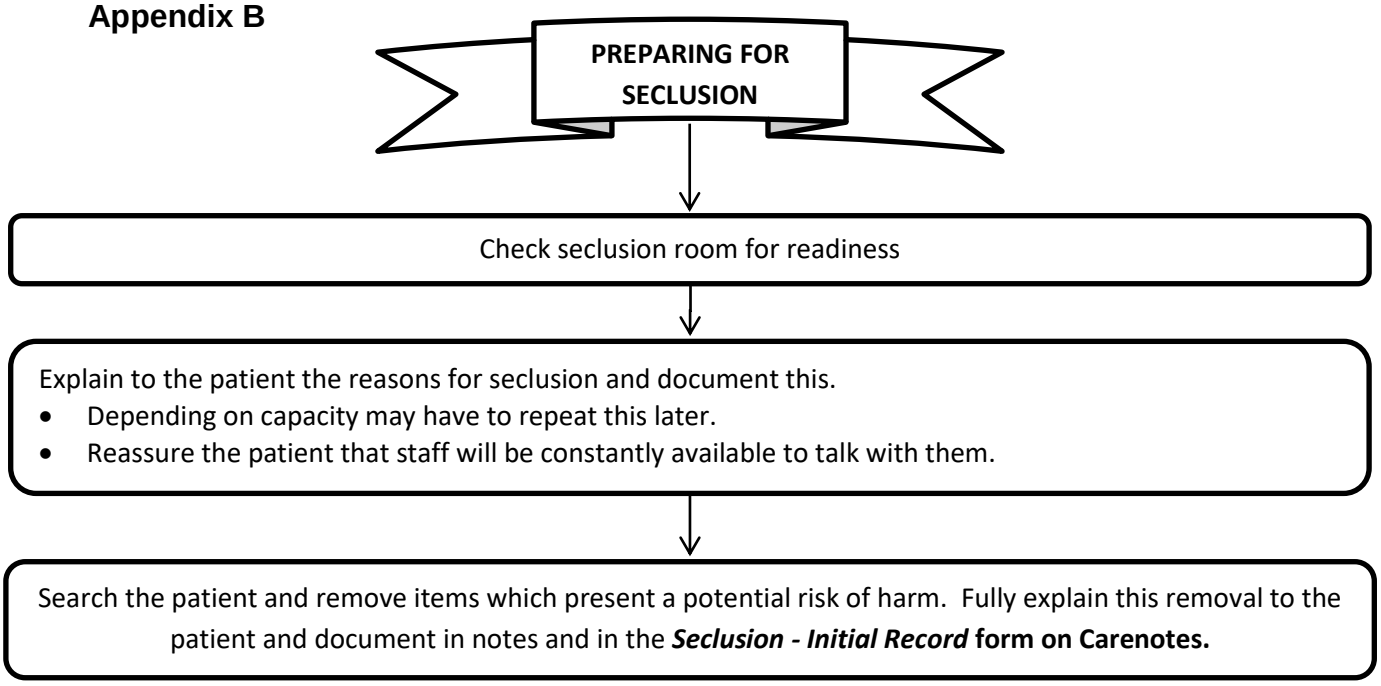
12.0 Appendices

Appendix A	Decision to Seclude Flowchart
Appendix B	Preparing for Seclusion Flowchart
Appendix C	Care in Seclusion Flowchart
Appendix D	Terminating Seclusion Flowchart
Appendix E	Long-term Segregation Flowchart

Appendix A


DECISION TO SECLUDE
Any decision to seclude must be proportionate, least restrictive, last for no longer than is necessary, and take account of patient preference wherever possible
Decision to seclude must be made by registered nurse, doctor or appointed clinician
Ensure:
1. The patient must be posing immediate and serious risk of harm to others
2. Less restrictive interventions have been tried and are documented in notes
3. Discuss with team on duty
Nurse in charge to complete Seclusion - Initial Record form and begin using Seclusion - Observation Recording Form in the patient's Carenotes
In hours Nurse in Charge must inform:
Ward manager
Matron
Responsible clinician or ward doctor
Out of Hours Nurse in Charge must inform:
Doctor on call
Senior person on site (e.g. Unit or Site coordinator/Duty Senior Nurse where applicable)
If doctor is not involved in decision to seclude there must be a medical review within 1 hour and complete the Initial MDT Review in the Seclusion - Initial Record form in the patient's Carenotes
Nurse in charge to complete web incident report form

Appendix B


PREPARING FOR SECLUSION
Check seclusion room for readiness
Explain to the patient the reasons for seclusion and document this.
• Depending on capacity may have to repeat this later.
• Reassure the patient that staff will be constantly available to talk with them.
Search the patient and remove items which present a potential risk of harm. Fully explain this removal to the patient and document in notes and in the Seclusion - Initial Record form on Carenotes.

Appendix C

CARE IN SECLUSION

Observing staff must be aware of any risks associated with the patient's current mental and physical health and presentation

Once in seclusion young person must be observed by sight and sound at all times. A record of the patient's behaviours and assessed mood should be made every 15 minutes and recorded on the *Seclusion - Observation Recording Form* on Carenotes. This form should also be used to record food and fluid intake in addition to use of toilet and bathroom facilities.

Arrange MDT review ASAP – complete outcome of this on *the* ***Seclusion - Initial Record*** **form on Carenotes**

If the Patient consents then ensure parents/carers/advocates are aware of seclusion taking place. Explain reasons and document this discussion and how contact can be maintained

Staff must complete a Seclusion Care Plan. This should include:

- What is required in order to terminate seclusion?
- Number of staff required to enter seclusion
- Safety, privacy and dignity issues
- Physical health
- Food, fluids, hygiene
- Administration of medication
- Emotional support
- Therapeutic activity (dependant on risk assessment)
- Contact with parents/carers

When the patient is using the bathroom ensure that at least I member of staff is with same gender that patient identifies with must be present – this should be documented.

Every 2 hours – nursing review should be completed using the ***Seclusion - Nursing 2 Hourly Review*** **form on Carenotes**

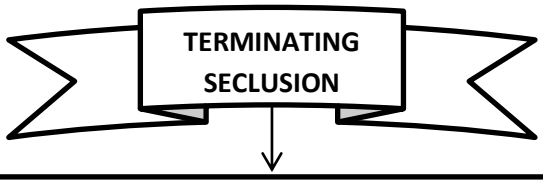
Every 4 hours – medical review should be completed using the ***Seclusion - Medical Review*** **form** on Carenotes until first MDT review (first MDT review must be arranged ASAP following seclusion) and documented in ***Seclusion - Initial Record*** **on Carenotes**. This includes weekends and bank holidays

Following MDT review medical review must take place at least twice a day – one to include review by responsible clinician (Consultant) – this should be recorded on ***Seclusion – Medical Review form***

After 8 continuous hours of seclusion or 12 hours of in 48 hours ➔Record on ***Seclusion - Independent MDT Review form*** on Carenotes.
This should include an Approved Clinician (consultant) not involved in the patient's care, senior nurse and other professionals not involved in incident leading to seclusion.
Independent MDT review repeated 8 hourly as long as the patient remains in seclusion.

If a patient makes a complaint about the use of Seclusion this must be reported to the Safeguard team

Appendix D



Seclusion ends when the patient is allowed free and unrestricted access to the normal ward environment. Decision to terminate can be made at any time by nurse in charge (in consultation with colleagues) or in any of the reviews.

Staff must ensure that the following are documented:

- Reasons for termination
- Discussions with other members of MDT – recording the times of these
- Post Incident Review with the patient including their perceived experience of seclusion

Post Seclusion Care Plan

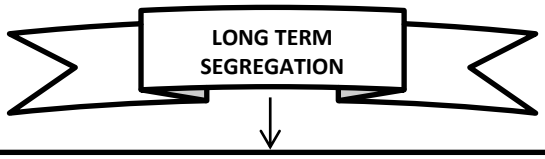
To include:

- Discuss care plan with the patient prior to them leaving seclusion.
- Arrangements to offer the patient the opportunity to discuss seclusion and events leading up to it ➔ this discussion should be documented in care notes.
- At least 15 minute intermittent enhanced obs until Nurse in charge reviews the patient's risk to self and/or others as manageable on general observations

Positive behaviour support plan must be completed when the patient is at further risk of needing restrictive interventions. The plan to include:

- Strategies to improve the patient's quality of life
- Recognition of the patient's individual signs of impending behavioural disturbance and how to respond
- Clear instruction on pre-planned use of restrictive interventions. This can include advance directives.
- To be completed within 24 hours of ending seclusion

Appendix E – Long Term Segregation



All staff involved in the provision of care during the use of seclusion and long term segregation must have received training in restrictive practice intervention and the policy for Seclusion and LTS.
When seclusion is terminated but risks remain high, it may be necessary to consider the use of long term segregation.

Seclusion – Long Term Segregation

Decision made by MDT, member of the commissioning authority. Views of family / carers should be sought where appropriate (with patient's permission)

Notification

Risk assessments for LTS completed - Clinical Director (CDS)
CDS Service Director and CDS Lead Nurse notified
Carenotes – Tab for Seclusion – LTS form to be completed
An incident form must be completed on Ulysses

Risk Assessment

LTS – is this clinically appropriate?
Proportionate to risk?
Consideration for safety of staff and others
Number of staff required
Risk assessment team – RC or deputy, two registered professionals (one from another ward)
Members of the ward clinical team

Care Plans

- My support and containment plan or Behaviour support plan to be reviewed and updated immediately and reviewed regularly as described in the policy
- Termination plan for LTS to be highlighted
- Rationale for decision clearly noted
- Plan of care must adhered to policy requirement
- All staff working in the ward environment must be appraised of the plan

Environment

Service users should have access to Bathroom, Bedroom, Lounge, Secure outdoor area.
Must be provided with a range of materials and activities of interest to that person.
Isolation – patients should not be isolated from contact with staff during LTS.
Observation level will be enhanced (see observation policy)
Enhanced observations – within eyesight
Staff should engage and not passively observe. All interactions to be recorded.

Reviews

Daily (at least) – led by an Approved Clinician and involving a registered professional from another ward.
Once weekly - at least once a week by full MDT (the RC or another Dr, a RN and another registered professional). Include IMHA when appropriate.
NB. Update commissioners when reviews of LTS lead to its continuation for 1 week or more
Monthly – if LTS continues, invite review led by 2 senior professionals from within Trust (not involved in the case). Also to include the CDS Clinical Director and Nurse Consultant/Lead Nurse
3-monthly – invite external Trust/ hospital professionals to lead review