Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Our Ref: NG/RM/24230
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Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 28th June 2024**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:
would like to request the following information under the Freedom of Information Act.

1. Your seclusion policy
2. An equality impact assessment associated with your seclusion policy. Please state if you do not have this documentation in place

Please see Appendix 1 attached

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Nicola Griffiths
Deputy Director of Governance

Document level: Trust
Code: R11
Issue number: 1

Seclusion and Long Term Segregation (LTS) Policy

Lead executive	Nursing Director
Authors details	Reducing Restrictive Practices Lead

Type of document	Policy
Target audience	All Trust staff involved in Seclusion and Long Term Segregation
Document purpose	The policy provides a set of standards and expectations to ensure that patients requiring seclusion or LTS receive safe, effective care which is compassionate and least restrictive practice remains at the forefront of clinical decision making.

Approving meeting	Quality Committee	Meeting date	7th March 2024
Implementation date	31st March 2024	Review date	31st March 2027

Trust documents to be read in conjunction with	
MHA18	Trust Policy MHA18, Deprivation of Liberty Safeguards, Policy, and Procedures (Mental Capacity Act, 2005).
R1	Trust Policy R1, Policy on the Use and Reduction of Restrictive Interventions Including the Use of Physical Holding Skills (Safety Interventions®);
1.27	Trust Policy 1.27, Policy for the Management of Violence and Aggression using Rapid Tranquillisation;
5.01	Trust Policy 5.01, Incident Reporting Policy and Guidance
R08	Refer to R08 Search of Patients (detained and informal), visitors and their property.
1.35	Trust Policy and Procedure for the Safe and Supportive Observation and Engagement of Patients

Document change history		Version	Date
What is different?	• Full Review of policy. • Changes to team name. (e.g. Reducing Restrictive Practices Team) • Changes to job titles (e.g. QILN and site manager) • Changes to training name (e.g. MAPA to safety interventions)	V1	
Appendices / electronic forms	• All appendices reviewed and updated;	V1	

	• Flow chart included around the 'Temporary Unavailability of Seclusion Suite or Emergency use of a non-designated seclusion area'. • Amendments made to 'Long term segregation process' flowchart with the addition of other examples of professions that can complete the periodic reviews.		
What is the impact of change?	• Policy now reflects CQC recommendations and more robustly reflects the requirements MHA Code of Practice for Seclusion and Long Term Segregation.	V1	

Training requirements	There are no specific training requirements for this policy.

Document consultation	
Directorates	All Heads and Clinical Directors of each Trust Directorate
Corporate services	Document quality group and Senior Operating Team Meeting
External agencies	N/A

Financial resource implications	None

External references

1. NICE (2015). Violence and aggression: short-term management in mental health, health and community settings. https://www.nice.org.uk/guidance/ng10;
2. NICE (2010). Delirium: Diagnosis, prevention and management. https://www.nice.org.uk/guidance/cg103;
3. NICE (2014). Head injury: Assessment and early management https://www.nice.org.uk/guidance/cg176
4. RCN (2010). Restrictive physical intervention and therapeutic holding for children and young people https://www.rcn.org.uk/__data/assets/pdf_file/0016/312613/003573.pdf
5. This policy should be read in conjunction with the NICE Guideline (2015) Violence and aggression: short term management in mental health, health and community settings;
6. Mental Health Act 1983 Code of Practice (2015, chapter 26. Safe and therapeutic responses to disturbed behaviour);
7. The Mental Capacity Act, 2005, Deprivation of Liberty Safeguards and the Use of Restrictive Interventions;

Monitoring compliance with the processes	Via SLT performance reporting and as part of the Trust Annual Audit Cycle.

outlined within this document	

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favorable / More favorable / Mixed impact
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
–		
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)	No	
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	

If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.	
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?	
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	NA
Enter details here if applicable	
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk	
Was a full impact assessment required?	No
What is the level of impact?	Low

Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There **is no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	✓
There **is** specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor				
Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse				

Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by		Date	

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Appendices

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1. Policy Introduction / Background

A safe and therapeutic culture should be provided for all people receiving treatment for a mental disorder including those who may present with behavioural disturbance. As a part of this there is often a requirement to balance the need for patient and staff safety against the need to ensure least restrictive practice for service users.

This policy outlines the procedure for utilising two such restrictive interventions, seclusion and long term segregation (LTS), recognising the need for these interventions to be used in a way that respects human rights and ensures these interventions are proportionate, in the best interests of the service user and use least restrictive principles.'

The policy provides a set of standards and expectations to ensure that patients requiring seclusion or LTS receive safe, effective care which is compassionate and least restrictive practice remains at the forefront of clinical decision making.

1.1 Policy Requirement

1.2 Policy Aim:

The Mental Health Act Code of Practice (MHA CoP) (2015, para 26.103) defines seclusion as "the supervised confinement and isolation of a patient away from other patients in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others".

If a patient is confined in a way that meet the definition above, even if they have agreed to or requested such confinement, they have been secluded. The use of any local or alternative terms (such as "therapeutic isolation") or the conditions of the immediate environment do not alter the fact that the patient has been secluded. It is essential that under such circumstances the person is afforded the procedural safeguards of the MHA Cop (2015).

The seclusion of a service user poses significant ethical and practical dilemmas, awareness of which is essential to promote best practice. Staff should be cognisant of the adverse effects on service users and the need to balance the rights of a person who is secluded to freedom, choice and autonomy with the rights of others to protection from harm. This should be underpinned by rigorous monitoring and evaluation, as outlined in this policy.

The policy aims to reinforce the least restrictive approach to ensuring that patients' needs are met safely and patients requiring seclusion and LTS are care for in line with the MHA CoP (2015).

1.3 Key Principle:

Least Restrictive Options:

The MHA CoP (2015) requires care and treatment to 'always be a means to promote recovery, be of the shortest duration necessary, be the least restrictive option and keep the patient and other people safe'.

In order to meet this requirement, when a person is at risk of presenting with challenging behaviour, assessment of the person's behavioural presentation is important in understanding an individual's needs and should seek to understand the behaviour in the broadest context.

Assessments should consider the views of patients and their families, carers and advocates. The results of the assessment should guide the development and implementation of effective, personalised and enduring systems of support that meet an individual's needs, promote recovery and enhance the quality of life outcomes for the individual and others who care and support them.

When concluded, assessments should describe behaviours of concern, identify factors which predict their occurrence, and describe the functions that behaviours serve or the outcomes they achieve for the individual. This then promotes the use of least restrictive options through proactive use of primary and secondary preventative strategies to respond to a person at risk of presenting with challenging behaviour.

Primary preventative strategies aim to enhance the person's quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbance.

Secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to avoid escalation of challenging behaviour. This includes the use of de-escalation strategies to promote relaxation.

De-escalation is the use of verbal and nonverbal communication to reduce or eliminate aggression and violence during the escalation phase of a patient's behaviour (National Institute of Clinical Excellence, 2005). De-escalation offers a safer, less coercive, and alternative to traditional containment methods, such as seclusion, rapid tranquilisation, intensive supervision or physical restraint (Lavelle et al, 2016).

North Staffordshire Combined Healthcare Trust (NSCHT) requires de-escalation strategies used by staff to be person-centred and should typically involve establishing a rapport and the need for mutual co-operation, demonstrate compassion, attentiveness and concern, negotiating realistic options, use of open questions, empathetic and non-judgemental listening, distracting and redirecting the person into alternate activities that are meaningful to them, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication. De-escalation strategies are non-confrontational and may, for a minority of patients, include prompts to encourage the person to access a low stimulus, private, relaxing

area if this is known to help the person calm; however there is no compulsion for the person to go to or to remain in such areas and staff must be mindful of this to ensure that seclusion or LTS criteria are not triggered or that the level of violence and aggression has escalated to the point where seclusion would be an appropriate intervention. A member of staff must remain with the person to offer intensive nursing support. Such de-escalation strategies may be used proactively as part of a person's care plan (or equivalent e.g. chained behaviour management plan) to meet their needs in the least restrictive way.

The care plan must be individualised, based on the assessment of a person's needs, including the continual attempt to understand the function of the behaviour for the person, consider the views of the person and their family/carers and be agreed by the multi-disciplinary team.

There must be regular review of the person and their care in line with the policy 1.35 Safe and Supportive Observation and policy 1.64 Effective Care Planning.

2. Policy Synopsis:

- To provide guidance on when any period of seclusion is indicated.
- To minimise the frequency and duration of any period of seclusion and minimise any possible anti-therapeutic effects.
- To ensure the welfare and care of a secluded service user is given highest priority.
- To ensure clinical accuracy of documentation thus providing a complete record of all periods of seclusion.

3. When seclusion can be used:

Seclusion may only be used for the containment of severe behavioural disturbance that is likely to cause harm to others. It may not be used solely as a means of managing self-harming behaviour (MHA CoP, 2015, para 26.108). When a patient poses a risk of self-harm as well as harm to others, seclusion should only be used when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety arising from their own self-harm and that any such risk can be properly managed.

Seclusion should not be used as a punishment or a threat, or because of shortage of staff. It must never form part of a treatment programme (MHA CoP, 2015, para 26.107).

Any situation whereby a service user is physically or mechanically confined to a seclusion room against their wishes should be regarded as the commencement of an episode of seclusion.

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

a) to manage severe behavioural disturbance which is likely to cause harm to others; and
b) as a measure of last resort.

During any period of seclusion it is vital that staff are aware of the need to maintain the service user's dignity. Staff must always be sensitive to age, gender, race, language preference and any sensory impairment and to determining the underlying cause of aggressive behaviour such as a culturally specific form of communication, or attempts to communicate by an individual with a sensory impairment/loss.

3.1 Summary of criteria:

Seclusion should only be considered when the following criteria/conditions are met:

- The nurse in charge, having made an assessment considers that there is an immediate risk of harm to others.

- All other interventions have been considered, attempted or are not feasible. In particular verbal de-escalation, listening skills, negotiation skills, diversion activities, increase in staffing levels and Safety Interventions® techniques.

Where possible when determining if seclusion is necessary, the following factors should be taken into account, clinical need, safety of patient and others, and, where possible, Advance Statements and agreed care plans. Seclusion must be a reasonable and proportionate response to the risk posed by the patient. Consideration should be given to using seclusion and/or rapid tranquillisation as alternatives to prolonged physical intervention and reflected in the individuals care plan and risk assessment.

3.2 Monitoring for Seclusion:

Each episode of Seclusion requires an incident (Ulysses) report.

Each ward utilising seclusion must have arrangements in place to scrutinise completion of documents used in seclusion (i.e. incident report, patient observation sheet and seclusion monitoring form).

Reporting of the initial decision to utilise seclusion will take place in the Trust Electronic Incident Reporting System (Ulysses) along with the Seclusion questionnaire also on Ulysses. There may be occasions of system failure, the 'downtime' paper based forms will need to be used and once the Electronic Patient Record (EPR) becomes available again the relevant seclusion/LTS forms should be transferred to the EPR, and the paper forms destroyed.

Audit of all seclusion documentation is part of the Trust annual audit cycle. Findings will be reported to the Trust Mental Health Law Governance Group.

A themed report of Seclusion and LTS practice is provided on an annual and quarterly basis for the Trust Board and periodic reports issued when requested.

On rare occasions and in some exceptional circumstances seclusion may take place outside of designated seclusion facilities, e.g., if the seclusion suite is not available to utilise however it is deemed necessary to seclude a patient. In these circumstances refer to appendix 10, Temporary unavailability of the seclusion suite or Emergency use of a non-designated seclusion are flowchart.
N.B please note
THE USE OF A NON-APPROVED ROOM TO CONFINE A PATIENT IS ONLY TO BE USED IN AN EMERGENCY AND FOR THE SHORTEST PERIOD OF TIME AS THIS DEPARTS FROM THE GUIDANCE IN THE MHA CODE OF PRACTICE.

3.3 Seclusion and Informal Patients:

Seclusion should only be used in hospitals and in relation to patients detained under the Mental Health Act (MHA) (2015). If an emergency situation arises involving an informal patient, and as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately (MHA CoP, para 26.106)

3.4 Seclusion and Advance Statements:

Patients must have the opportunity to complete an advance statement that expresses their preference on how an episode of severe behavioural disturbance should be dealt with. The purpose of this is to minimise the use of restraint, seclusion and LTS. Nevertheless, the Trust recognises that some patients may indicate, as part of their advance statements, that they would choose seclusion over restraint as a way of managing their behaviour. In such circumstances, it must be explained to the patient

that the Trust is obliged to attempt de-escalation in the first instance and seclusion is a measure of last resort to be used only for managing behaviour that may harm others and cannot be included in a patients care plan.

3.5 Advance Care Planning/ Positive Behavioural Support Planning:

All patients who may be at risk of engaging in severe behavioural disturbance likely to cause harm to others should have a care plan (some services use the term positive behaviour support plan or RAID (reinforce appropriate, implode disruptive) plans). Input should be sought from the patient in developing this plan, and where appropriate, from family members and carers. This plan should be clearly entitled and should describe the interventions that effectively manage incidents of severe behavioural disturbance for that patient.

Where it has been agreed in a Care plan/ positive behaviour support plan with the patient that family member's carers or Independent Mental Health Advocates (IMHA) will be notified of significant behavioural disturbances and the use of restrictive interventions, this should be done as agreed in the plan. For patients under the age of 16 years, persons with parental responsibility (parents, family members or local authority children's services for looked after children) must be informed each time seclusion is utilised. For patients between the age of 16 and 18 years, information may be shared with those with parental responsibility with the patient's consent.

A well-drafted care plan/positive behaviour support plan that is focused on understanding the patient's behaviour in the context of their needs may help to minimise the use of seclusion.

3.6 Additional Considerations for Children and Young People

Restrictive interventions such as seclusion and LTS should only be applied to children and young people after considering their physical, emotional and psychological maturity.

Staff must be mindful that seclusion or LTS, whilst traumatic for any individual may have particularly adverse implications for the emotional development of children and young people and should take this into account before making a decision to seclusion or LTS.

A child and adolescent trained clinician should make a careful assessment of the potential effects of seclusion, especially if the child or young person has a history of trauma or abuse. Seclusion or LTS should only be used when other strategies to de-escalate behaviours and manage risks have been exhausted.

Seclusion should only be used in hospitals and for children and young people who are detained under the MHA (2015).

4. Who else needs to be informed when initiating seclusion?

Family members, carers or Independent Mental Health Advocates (IMHA) should be informed, as agreed in the advance care plan/positive behaviour support plan. For young people under 18 years (See above section).

5. Seclusion Environment:

Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purpose of seclusion and which serves no other function on the ward (MHA CoP, para 26.105).

The seclusion room or suite should (MHA CoP, para 26.109):

- Allow for communication for the patient when the patient is in the room and the door is locked, e.g. via an intercom
- Include limited furnishings which should include a bed, pillow, mattress and blanket or covering
- Have no 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 when required
- Have a clock that is always visible to the patient from the room
- Have access to toilet and washing facilities

Resuscitation equipment is available within the observation area of the seclusion suite including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, intravenous fluids, and suction.

Within the Trust the only recognised seclusion room is within psychiatric intensive care unit (PICU) at Harplands Hospital. Where assessment indicates, other services within the Trust may have to consider the transfer of a patient to this ward.

Any intervention that meets the definition of seclusion, including such interventions that occur outside of designated seclusion rooms, must be treated as seclusion and the safeguards implemented (see section 3.2)

Staff must be mindful of the risks in attempting to move a service user from one area of the ward to another when they are resistive to this and in a high level of arousal/distress. In most cases best practice would suggest that wherever possible it would be preferable to initially manage the incident where it occurs at least until the service user becomes more agreeable to being moved. This may require staff to ask other service users to leave the area in order to maintain privacy/dignity.

6. Temporary Unavailability of Seclusion Suite or Emergency use of a non-designated seclusion area:

There may be occasions when the seclusion room is not available. The use of a non-approved room to confine a service user should only occur as an emergency measure, be reasonable and proportionate to the harm it is intended to prevent, be for the minimum time necessary. The full safeguards of this policy apply and must be implemented for such incidents of seclusion AND, both the Chief Nurse and the Mental Health Act Manager should be informed.

The environmental risks posed when using non-approved seclusion rooms must be noted and actions taken to safeguard both patients and staff. The use of enhanced observation levels (minimum level 3) and increased staffing levels must be part of the measures used to maintain safety of all concerned.

All reasonable efforts must be made to transfer the service user to a safer environment at the earliest opportunity and prompt referral to a PICU should be considered once the patient is deemed suitable to leave the seclusion room (this maybe an external PICU as well as PICU at NSCHT), the principles of seclusion regarding nursing and medical reviews must be applied. This ensures the provision of regular external clinical review of the intervention thereby providing greater safeguards for both patients and staff.

In such emergency situations, staff must understand that the use of a bedroom or non-recognised environment for seclusion, departs from the guidance in the MHA Code and as such the reasons and rationale must be clearly recorded in the service users clinical notes.

Staff should clearly indicate in the seclusion documentation where the seclusion took place and the reasons why the seclusion room was not available. All actions must be documented within the EPR.

The Seclusion Care Pathway Procedure:

7. Who can authorise seclusion?
Seclusion may be authorised only by the following:

- A psychiatrist
- An approved clinician who is not a doctor
- The professional in charge of a ward (e.g. lead nurse)

All attempts must be made to manage the patient's severe behavioural disturbance by other means. Seclusion should be used only when all other means have been exhausted

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

7.1 Who needs to be informed?

When the decision to initiate seclusion is made by:

- the professional in charge, by
- a psychiatrist who is neither the patient's Responsible Clinician nor an approved clinician, or
- by an approved clinician who is not a doctor, they should immediately inform the following personnel that the patient has been secluded:

a) The patient's Responsible Clinician or if unavailable, the duty doctor (this can be the trainee psychiatrist on-call)

AND

b) The Quality Improvement Lead Nurse/ Matron, in hours and site manager out of hours.

Communicating with the personnel listed above should be within 30 minutes of the initiation of seclusion or as soon as is practicable and safe.

If seclusion is authorised by a psychiatrist, the first medical review will be the one they undertook immediately before authorising seclusion.

8. Initiation of Seclusion:

In the event that all other least restrictive options have been exhausted and there are increasing concerns regarding the safety of the patient and / or others; it is permissible for the professional in charge or the patients Responsible Clinician or approved clinician to make a decision to utilise seclusion.

Staff must complete an incident form including the seclusion questionnaire (Ulysses) and initiate the seclusion monitoring form within the patient's electronic patient record (EPR).

8.1 Responsibilities of Professional in Charge:

In addition to completing the incident and seclusion monitoring form's the professional in charge of initiating the seclusion should:

- Complete the Seclusion Monitoring form (this will remain paper based and available in the seclusion suite)

- Plan to rotate staff so that a member of staff trained to carry out such observations is observing the patient in seclusion at all times and inform staff of the existence of such roster

- Inform the care team of the seclusion and delegate responsibility for other patients to members of the care staff

- At each review point (see section 8), assess and decide whether it is appropriate to end seclusion.

- Complete a seclusion care plan on the EPR if seclusion continues beyond the first medical review

- Ensure that the patient's vital signs are identified and recorded accurately in accordance with NICE guidance on monitoring vital signs is given with regards manual restraint, rapid tranquilisation, and delirium and head injury

- Make an entry in the progress notes section of the EPR during each shift to indicate that the patient remains in seclusion

- Ensure that resuscitation equipment is available within the observation area of the seclusion suite and that this is checked on a daily basis

9. Searching the patient prior to seclusion:

A member of the care team shall carry out a visual search of the patient to reduce availability of objects that could be used as a weapon, i.e. shoes, belts, lighters/matches, keys and any other items on the person that may be deemed harmful to them or others.

If staff members feel that a physical search is required, the policy on search of patients and their property must be adhered to and their rights incorporated. Reference should be made to the Trust's Policy for Searching Patients and their Property – R08.

10. Privacy and Dignity of the person using seclusion:

Staff may decide what the patient may take into the seclusion room or suite based on their clinical risk assessment, but patients should wear their personal clothing and retain other personal items such as those of cultural or religious significance, if this does not compromise the safety of the patient or other people.

It may be necessary to remove articles of clothing from the patient, if those clothes are deemed a risk to their safety. Should this occur, the privacy and dignity of the patient will be respected while alternative, 'anti-rip' clothing is provided. Sanitary products should be made available within the seclusion suite.

The seclusion suite is equipped with live feed non-recordable CCTV. The images are relayed to a monitor that is placed outside the seclusion room to provide better observation by increasing the field of vision.

When the patient first enters seclusion the CCTV is to be switched off in the toilet/shower area. The CCTV must only be used in the toilet/shower area if it is clinically indicated as being in the best interest of the patient. The decision to use CCTV in the toilet/shower area must be informed by an appropriate risk assessment, reflected in the patient's seclusion care plan and recorded in the clinical EPR. There must be clear statements explaining the reason why observations in the toilet/shower area would be via the CCTV monitor, duration and patient presentation / risk factors deeming this appropriate.

The privacy and dignity of the patient must be taken into account and balanced against the potential risk factors when making a decision, about whether the CCTV needs to be turned on within the toilet and shower areas of the suite.

At all subsequent monitoring reviews (by Professionals, MDT and Medical staff), a review of the patients privacy and dignity must be included to establish; where a decision has been made to turn the CCTV on, if the CCTV can safely be switched off in order preserve the individuals privacy and dignity. Each decision must be documented on the patients seclusion record and added to the seclusion care plan where considered necessary and should highlight the rationale and risks identified to either keep the CCTV on or turn it off.

11. Care of the patient in seclusion:

11.1 Who should be observing the person in seclusion?

A suitably trained member of staff who has received an induction regarding the seclusion policy, processes and procedures, should as a minimum be readily available within the seclusion suite at all times throughout the period of seclusion. A registered practitioner should be readily available and contactable at all times throughout the period of seclusion.

Ward staff should only carry out constant observation for periods not exceeding 2 hours before handing over to another staff member except in exceptional circumstances. Records must be contemporaneous. In line with the Trust Policy and Procedure for the Safe and Supportive Observation and Engagement of Patients.

The observing practitioner must have access to a personal alarm and they must retain the keys to the seclusion door.

Consideration should be given to gender of the person undertaking observations; this may be informed by the consideration of a patient's trauma history, religious or cultural beliefs.

11.2 Clinical observation:

The aim of clinical observation is to safeguard the patient, monitor their presentation and behaviour and to identify the earliest time at which seclusion can end.

The patient's behaviour, mental state and physical health should be constantly observed using Level 3 Observation as per policy by staff who have been inducted into the use of the seclusion suite and the practice of undertaking observations throughout the period of seclusion.

11.3 How often should observations be recorded?

Staff must complete the Seclusion Observation Record Sheet (appendix 6) every 15 minutes (MHA CoP para 26.123).

This will remain paper-based and will need to be scanned into EPR (patient clinical notes section) at the end of every 24hr period.

As good practice, a record should be made of the patient's appearance, what they are doing and saying, their mood, their level of awareness and any evidence of physical ill-health especially with regard to their breathing, pallor or cyanosis.

Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

11.4 Observation following rapid tranquilisation:

For patients who have received sedation, a member of suitably trained staff will need to be outside the door at all times (MHA CoP, para 26.122). They must observe respiratory rate and depth, bodily movements, colour and complexion of patient, levels of consciousness. The Trust Policy 1.27, Policy for the Management of Violence and Aggression using Rapid Tranquillisation; must be followed and observations recorded on a NEWS 2/PEWS tool.

If it is unsafe to approach the service user to obtain physical observations using, the Non-Contact Physical Health observations form (within NEWS 2/PEWS) can be utilised.

The length of time for this additional observation should be care planned in discussion with the staff taking into account the rapid tranquilisation policy.

12. Seclusion Care Plan:

Staff should complete the form "Seclusion – Care Plan" Which can be found within the "Intervention Plan" on the patients EPR.

What should be in a seclusion care plan?

A seclusion care plan should set out how the individual needs of the patient will be met whilst in seclusion and record the steps that should be taken to terminate seclusion as soon as possible. It will include the following:

- A statement of clinical needs, including physical and mental health.

- A plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed.

- Details of bedding and clothing to be provided.

- Details of how the patient's dietary needs will be met.

- Details of any family or carer contact/communication as per agreement in the Advanced Care Plan / Positive Behaviour Support Plan, this should include any gender specific requirements, and should consider the principles of trauma informed care.

- Details of any activities that should be made available to the patient whilst in seclusion. This should include such things as reading materials, entertainment facilities, rehabilitation input, spiritual support, access to physical exercise and specify the conditions under which these are to be facilitated.

- Details of the support that will be provided to the patient when seclusion ends.

The patient should be encouraged to contribute to the seclusion care plan and steps should be taken to ensure that the patient is aware of safety aspects that need to be adhered to for seclusion to end.

13. Reviews during Seclusion:

The need to continue seclusion should be reviewed in accordance with the procedure laid out in the Code of Practice (MHA CoP, para 26.112). The following principles apply:

• If not authorised by a psychiatrist, there must be a medical review within one hour or without delay if the patient is not known or there is a significant change from their usual presentation.
• Seclusion area to be within constant sight and sound of staff member
• Documented review by person monitoring at least every 15 minutes
• Nursing reviews by two nurses every two hours throughout seclusion
• Continuing medical reviews every four hours until first (internal) MDT
• First (internal) MDT as soon as is practicable
• Independent MDT after 8 hours consecutive or 12 hours intermittent seclusion (within a 48 hour period)
• Following first (internal) MDT, continuing medical reviews at least twice daily (One by Responsible Clinician)

• Following the Independent MDT, continuing (internal) MDT review at least once Daily
• **NB** – Family /Carers should be informed of the outcomes of each review.

13.1 Who should undertake the medical review?

If seclusion is authorised by a Consultant Psychiatrist, then the Consultant Psychiatrist will have seen the patient immediately prior to authorising seclusion. Their assessment may be the first medical review for the purpose of this policy.

If seclusion is authorised by an Approved Clinician who is not a doctor, or the professional in charge of the ward, or a Psychiatrist who is not a Consultant, the first medical review should be undertaken by the patient's Responsible Clinician or the duty doctor (out of hours) within an hour of the commencement of seclusion.

Overnight and on weekends, when the patient's own Responsible Clinician may not be available, the duty doctor must have access to an on-call doctor who is an approved clinician.

13.2. What needs to be included in the first medical review?

NB – any records recorded onto a paper document must be uploaded into the EPR within 24hrs of completion.

The doctor who completes the first medical review must:

- Undertake a medical assessment of the patient's mental and physical state.
- Record any obvious injuries
- Enter the assessment and action plan into the patient's EPR on the seclusion monitoring form.
- If it is agreed that seclusion should continue, a seclusion care plan should be agreed and prepared by the professional in charge and completed on the EPR.

At each review, if it is agreed that seclusion will continue appropriate amendments should be made to the seclusion care plan.

All subsequent medical reviews should be undertaken by the Responsible Clinician, a doctor who is an approved clinician, or the duty doctor.

13.3 What further reviews are required?

At each review staff should complete the form Seclusion monitoring form on the EPR (Or paper until the EPR is updated) choosing the appropriate review type on the form.

All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient's mental and physical state. Where agreed within the Multi-Disciplinary Team (MDT), family members should be advised of the outcomes of reviews.

Patients and their families should be as fully involved as possible in developing and reviewing positive behaviour support plans (or equivalent). Patients eligible for support from an IMHA should be reminded that an IMHA can support them in presenting their views and discussing their positive behaviour support plan. The preparation of positive behaviour support plans also provides an important opportunity to record the wishes and preferences of families and carers and the involvement they may wish to have in the management of behavioural disturbances. Patients must consent to the involvement of families or IMHA's if they have capacity to give or refuse such consent.

13.4 Nursing reviews

Two Registered Nurses should review the patient every two hours from the commencement of seclusion. At least one of these two Registered Nurses should not have been involved directly in the decision to seclude.

Nursing observations should be documented every 15 minutes**,** who is within the seclusion suite at all times (completed on the paper seclusion observation sheet – Appendix 6).

At any time staff should raise any concerns about the patient's condition with the Responsible Clinician or duty doctor.

The nurse in charge can end seclusion at any time if their assessment supports this. Unless the MDT have already determined the time that seclusion should end or be reviewed to end.

13.5 Medical Reviews

Medical reviews must take place every four hours until the first (internal) MDT review has taken place, including in the evenings, night-time, on weekends and on bank holidays. See section 13.9 for when the patient in seclusion is asleep. This will be the duty Doctor in consultation with the on-call approved clinician where necessary.

Medical reviews will include the following:

- A review of the patient's physical and psychiatric health
- An assessment of the adverse effects of medication
- A review of the observations required (the minimum prescribed in this policy must be adhered to)
- A re-assessment of medication prescribed
- An assessment of the risk posed by the patient to others
- An assessment of any risk to the patient from deliberate or accidental self-harm
- As assessment of the need to continue seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner

13.6 MDT Reviews

First (Internal) MDT Review: This should be held as soon as is practicable. Membership should include:

- the Responsible Clinician/a doctor who is an approved clinician or an approved clinician who is not a doctor but has appropriate expertise
- a senior nurse on the ward (band 6 or above)
- staff from other disciplines who would normally be involved in patient reviews

13.7. Further reviews required:

Medical review - After the First (internal) MDT, further medical reviews will take place at least twice daily in every 24 hour period. At least one will be carried out by the patient's Responsible Clinician, or an alternative approved clinician or duty doctor out of hours.

One of the two medical reviews should be an MDT review, involving staff from other disciplines who would normally be involved in patient reviews, in addition to a doctor and a nurse.

13.8. Independent MDT reviews

This should be held when a patient has been secluded for eight hours consecutively or for 12 hours intermittently in a 48 hour period. Minimum membership will include:

- a doctor who is an approved clinician or an approved clinician who is not a doctor
- a nurse
- Other professionals not involved in the incident which led to seclusion and an Independent Mental Health Advocate (IMHA) if possible

The Code of Practice does (MHA CoP 26.136) not specify the membership of the Independent MDT Review at weekends and overnight. The Trust therefore requires the review to be carried out by the Duty Doctor in consultation with the on-call Approved Clinician, a nurse as well as a senior nurse (band 6 or above) all of whom were not in the incident which led to seclusion.

If it is agreed by the Independent MDT review that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan.

13.9. What happens if a review is required and the patient is asleep?

When the patient in seclusion is asleep, the Code of Practice (MHA CoP 26.136) allows Trusts to make different review arrangements in order to avoid waking the patient. Therefore, between 2300 hours and 0700 hours, medical and nursing reviews, First (internal) MDT review and Independent MDT reviews may be suspended if the patient is asleep.

In these circumstances, it must be documented that the patient was asleep and the review deferred until the patient is awake or 07:00hrs; whichever is sooner.

At other times, if the patient is asleep, attempts should be made by professionals to wake the patient up, if appropriate.

13.10. MDT reviews required at weekends

At weekends and overnight, membership of the MDT reviews is likely to be limited to medical and nursing staff, therefore the Site Manager should be involved and an on-call Approved Clinician. If the site manager is not a nurse, a senior nurse from another clinical area on the Harplands site will be requested to complete the seclusion review.

13.11. Resolving disputes about ongoing seclusion

If any member of the multi-disciplinary team attending any review disputes the continued need for seclusion, the matter must be referred to either the Quality Lead Nurse / Service Manager or out of hours; the Site Manager. Furthermore, the opinion of another approved clinician should be sought. For out of hours, as well as referring the matter to the on call manager, an opinion should be sought from the on-call consultant, and the on-call local manager advised of the outcome of the review.

14. Ending Seclusion:

Seclusion should immediately end when an MDT review, a medical review or the independent MDT review determined that it is no longer warranted. Alternatively, when the professional in charge of the ward considers that seclusion is no longer warranted, it may be terminated following consultation with the patient's Responsible Clinician or the duty doctor, either in person or the telephone (MHA CoP, para 26.144).

The Trust requires the nurse-in-charge to regularly assess and decide, in consultation with the senior individual on duty (i.e. Ward Manager, Quality Lead Nurse / Service Manager, or the Site Manager; out of hours) whether it is appropriate to end seclusion. Again if the site manager is not a nurse, a senior nurse from another clinical area will undertake this task.

Seclusion ends when the patient is allowed free and unrestricted access to the normal ward environment or transfers or returns to conditions of LTS (MHA CoP, para 26.145)

Opening a door for toilet or food breaks or medical reviews do not, in themselves, constitute the end of seclusion.

The MHA Code of Practice recommends that in order to minimise the impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive

manner possible. Where seclusion is used for prolonged periods, as a means of assessing the level of risk, flexibility may include allowing the patient to receive visitors, facilitating brief periods of access to secure outdoor areas or allowing meals to be taken in general areas of the ward. Such flexibility should be considered during any review, and it may provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without termination the seclusion episode (MHA CoP, para 26.111).

Staff should complete the Seclusion monitoring form to clearly indicate when and how the seclusion period was discontinued.

15. Re – integration to the ward & debriefing:

Following a period of seclusion the clinical rational should be explored with the patient, and they should be supported in the process of re-integration to normal ward activities. Nursing time should be set aside to facilitate this process.

Debrief discussions will include the following:

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

15.1. Ongoing care planning:

The above discussion will feed into a review of the patient's ongoing Care Plan or Positive Behaviour Support Plan.

15.2. Debrief:

Post-incident debrief should be available to both staff and patients. Staff should be aware of Trust facilities for debriefing and should access this as required.

16. Reporting & Monitoring:

In addition to Incident 'Ulysses' reporting, the following people must be informed at commencement of seclusion:

- Quality Lead Nurse/Matron/ Service Manager

- Associate Director for the Service or nominated manager.

17. Seclusion reviews at times of major disruption:

In the rare event of major disruptions (such as severe adverse weather or transport disruptions) which prevent access to or from inpatient sites over many hours, it may not be possible for doctors to attend in order to carry out seclusion reviews in person, as prescribed by this policy.

If no doctor is available, the senior nursing team (i.e. Ward Manager, Quality Improvement Lead Nurse / Service Manager, Nurse Practitioners) in the inpatient ward should make telephone contact with the required doctor, discuss the patient's presentation, make a decision about whether seclusion is to continue, and record this in the appropriate review form in the EPR.

If seclusion continues, the patient should be reviewed by a doctor as soon as one is next available.

This is to be done only in the event of major disruptions which prevent physical access to the inpatient units. It is otherwise the expectation that all reviews will be completed as prescribed in this policy.

18. Seclusion MUST not be used in the following circumstances:

- As a punishment or a threat
- As part of a treatment programme
- As a means of managing staffing shortfalls

Long Term Segregation Care Pathway Procedure:

19. Longer Term Segregation (LTS):

19.1. CODE OF PRACTICE DEFINITION OF LONG-TERM SEGREGATION & GENERAL

Principles:

The Mental Health Act Code of Practice (CoP) 2015 defines LTS as follows. “Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determine that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment.

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 harm over a prolonged period of time.” (MHA CoP, para 26.150)

The Code of Practice further states that “it is permissible to manage this small number of patients by ensuring that their contact with the general ward population is limited” (MHA CoP, para 26.151).

There are exceptional circumstances where LTS for an individual is in their best interest, despite it not directly being associated with a risk of violence or aggression (i.e. due to an individual’s sensory needs and associated distress/ risk when in the general ward environment). This policy will therefore apply to ALL individuals who are segregated from the general ward environment.

20. When should LTS be considered?

LTS may only be considered when:

- All other forms of treatment and management have been considered as ineffective/ inappropriate (e.g. Positive Behavioural plans including those to tackle incidents of violence and aggression, rapid tranquilisation and seclusion).
- It is in the best interests of the patient
- It is proportionate to the likelihood and seriousness of the harm threatened
- There is no less restrictive alternative
- A patient may be felt to require LTS after a period in seclusion, when attempts to end seclusion have failed repeatedly due to ongoing high risk of harm towards others. In such cases, a decision should be made by the patient's Responsible Clinician about whether the use of LTS may be more appropriate than long periods in seclusion

LTS may only be considered for patients detained under the MHA (1983).

20.1 Who needs to be involved in decisions relating to LTS?

Discussion must take place with the patient and their relatives or carers or advocate. The Code of Practice states that "…when consideration is being given to LTS wherever appropriate, the views of the person's family and carers should be elicited and taken into account…" (MHA CoP, para 26.150).

21. Long –Term Segregation environment:

The CoP states "…the environment should be no more restrictive than necessary. This means that it should be as homely and personalised as risk considerations allow…" (MHA CoP, para 26.151)

The minimum facilities required are:

- Bathroom facilities
- A bedroom
- Relaxing lounge area
- Access to secure outdoor areas
- Range of activities of interest and relevance to the patient

22. Initiating Long -Term Segregation:

It is anticipated that there would only be a very small number of Trust inpatients who would require LTS whereby their contact with the general ward population is strictly limited.

At the Harplands clinicians should consider the transfer of an individual to the Psychiatric Intensive Care Unit (PICU), specific guidance for this service (Psychiatric Intensive Care Unit-Operational Framework) is available at the Harplands.

The decision to initiate LTS must be made by the MDT; it is then the responsibility of the patient's Responsible Clinician to complete the initial "Long-term Segregation monitoring form"

Additionally; The CoP requires a representative from the responsible commissioning authority to be involved in the decision to initiate LTS (MHA CoP, para 26.150).

22.1 Clinical Incident Form:

Where a decision to utilise LTS has been made an incident report must be completed by the nurse in charge. This will include:

- The time date and time LTS commenced and the name and designation of the person making the decision
- The full reasons for the commencement of LTS
- The time LTS ended and the rationale for this decision

The use of LTS should be regarded as an "extra-ordinary event". It should therefore trigger a retrospective investigation report by the Quality improvement Lead Nurse / Service Manager.

22.2. Who else must be consulted when initiating LTS?

A decision to place a patient in LTS may only be made by the patient's Responsible Clinician and the multi-disciplinary team. Others who must be consulted:

- The views of the patient and their family/carers should be sought and taken into account

- If it is felt that the patient may lack capacity to understand the rationale for LTS, a capacity assessment must be carried out. If the patient does lack capacity, all decisions made in their best interests should be documented

- The patient's Independent Mental Health Advocate (IMHA) should be consulted. A representative from the responsible commissioning authority should be consulted

- The local safeguarding team should be informed

23. Care of the Person in Long-Term Segregation:

The CoP states that "patients should not be isolated from contact with staff or deprived of access to therapeutic interventions" and "it is highly likely they should be supported

through enhanced observations" (MHA CoP, para 26.152).

Services must make an assessment of the appropriate enhanced observations required for supporting the patient and for the safe management of the patient's sustained risk of harm to others. This will generally be a minimum of 2:1.

Staff supporting the patient in LTS should make written records of the patient's condition at least every hour.

It may become necessary for a patient to be placed in seclusion while they are in LTS, if there is acute behavioural disturbance where there is a need to contain an immediate risk of harm to others. At such times, the procedure for seclusion as laid out in this policy should be followed. When seclusion is terminated, the patient will return to LTS.

24. Long-Term Segregation Care Plan:

Staff must complete a LTS Care Plan on the EPR.

24.1 What should be in the Care Plan?

Every patient in LTS must have a specific LTS treatment plan. This should be prepared with input from the patient, where possible.

The aim of the treatment plan should be to end LTS (MHA CoP, para 26.152)

The LTS treatment plan should clearly state why LTS is necessary and should be supported by a comprehensive risk assessment and therapeutic plan.

The LTS treatment plan must detail the steps and therapeutic goals to be achieved in order for LTS to be terminated.

24.2 Who should we share the LTS care plan with?

The patient should have access to a copy of the LTS treatment plan, where possible. If this is not appropriate or possible, the patient must be informed of the steps and therapeutic goals they should achieve in order for LTS to be terminated.

Patients in LTS, and their relatives/carers should be given information by the Ward Manger or Responsible Clinician regarding:

- the visiting arrangements based on risk assessment
- Emergency procedures e.g. PIT alarms, staff response etc

The information given to the patient must meet the individual's communication needs, for example people with additional needs such as physical, sensory or learning disabilities, and people who do not speak or read English.

25. Reviews during Long-Term Segregation:

Every formal review should attempt to determine if the risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their health and welfare.

Less restrictive means of managing the patient's risks towards others must be considered at every stage.

25.1 LTS will be reviewed as follows:

Overview of LTS and Monitoring Process:

- Written record every hour by person supporting the patient in LTS.
- Daily review by an approved clinician, (who need not be a doctor)
- At least weekly review by the full MDT (including patient's Responsible Clinician or deputy, ward manager or deputy, and IMHA)
- Weekly review by a consultant psychiatrist not involved with the patient
- If LTS continues beyond 3 months, review by an external hospital, and discussion with IMHA and commissioner

25.2. Hourly Observation

Staff supporting the patient in LTS should make a record of the patient's mental state, communication, behaviour and risks to self and to others on at least an hourly basis.

Staff must complete LTS observation record**.** This will remain a paper document and must be scanned into Lorenzo (patient clinical notes section) every 24hr period (Appendix 7).

25.3. Daily Reviews

There must be a daily review by an approved clinician, who need not be a doctor. This should be recorded in the electronic progress notes.

The approved clinician must complete LTS observation form to indicate that the review has taken place and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

On weekends, the review may be conducted by telephone with nursing staff contacting the on-call consultant. Nursing staff will then complete the "Long term Segregation observation form" and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

25.4. Weekly Reviews:

The weekly review by the MDT should be carried out by the patient's Responsible Clinician or deputy, the ward manager or deputy, other members of the MDT who would normally be involved in the patient's care and the patient's IMHA.

Consideration should be given to whether less restrictive alternatives of managing the patient's risk to others are appropriate, and to provision of a full therapeutic programme, including, where appropriate, access to visitors. These considerations must be documented as part of the MDT review within Lorenzo.

Staff must complete the "Long-Term Segregation observation record sheet (Appendix 7) to indicate that the review has taken place and document the findings in the Clinical Note section on the EPR, choosing the appropriate review title.

Where successive MDT reviews determine that LTS continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner (MHA CoP, para 26.159)

The MHA CoP (2015) also requires periodic review of LTS by a senior professional not involved with the case (para 26.155). To meet this requirement, a weekly review of the patient and the treatment plan must be undertaken by a consultant psychiatrist who is not otherwise involved in that patient's care. The psychiatrist should complete the 'Long-Term Segregation observation' form to indicate that the review has taken place and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

25.5. Review of Extended Long-term segregation

If LTS continues beyond three months, a comprehensive review must be undertaken by an external organisation. The clinicians involved in this review must discuss the care of the patient with the patient's family, IMHA and the responsible commissioners. A written report should be provided to the detaining authority (e.g. Mental Health Law Team or Ministry of Justice).

This review must be repeated every 3 months as long as LTS continues. This must be documented in 'Long- Term Segregation observation' form to indicate that the review

has taken place and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

26. Termination of Long-Term Segregation:

LTS must be terminated when it is determined that the patient's risks have reduced sufficiently to allow them to be re-integrated into the ward.

The decision to terminate LTS should be taken by the MDT, following a thorough risk assessment and taking into account observations from staff of the patient's presentation during close monitoring of the patient's presentation in the company of others.

The MDT should consist of, as a minimum, the patient's Responsible Clinician and the Ward Manager. The patient's IMHA should also be consulted.

The RC and Ward Manager should complete the form "Long-term Segregation – observation form" and document the findings in the Clinical note section on the EPR, choosing the appropriate review title on the EPR.

27. Re-integration to the ward and Debrief:

The patient's LTS Care Plan and MDT review documentation should include a detailed account of all the steps to end LTS. The care plan should detail how the patient will be re-integrated back into the wider ward. It is expected that this will take place over a period of time, allowing the patient to gradually re-acclimatise to being in the company of other patients and staff.

Following the termination of LTS and complete re-integration into the ward, the patient should have a de-briefing session to explore their experience of LTS, their understanding of the rationale for it, and their current risks towards others.

28. Reporting and Monitoring:

In addition to Incident 'Ulysses' reporting, the following people must be informed at commencement of LTS, weekly reviews, and at termination:

- Associate Director of the Directorate

  Chief Nursing Officer
- Safeguarding Team

- Mental Health Law Manager

29. Trust Wide Monitoring of Seclusion and Longer Term Segregation:

The relevant directorate Clinical Director must monitor the use of seclusion within their services. The use of the Incident Reporting system and subsequent Investigation Report will allow for the monitoring of seclusion within clinical services and generate reports to provide assurance to the Senior Leadership Team meeting.

The Reducing Restrictive Practice Lead will produce quarterly figures on the use of seclusion within services and these will be presented to the Quality Committee on a quarterly basis.

30. Evaluation and Audit

The Trust will annually consider evaluation and audit of seclusion and LTS as part of the Trusts annual audit cycle.

31. References:

Department of Health (2005): The Mental Capacity Act. Deprivation of Liberty Safeguards and the use of Restrictive Interventions.

Department of Health (2015): The Mental Health Act 1983: Revised Code of Practice.

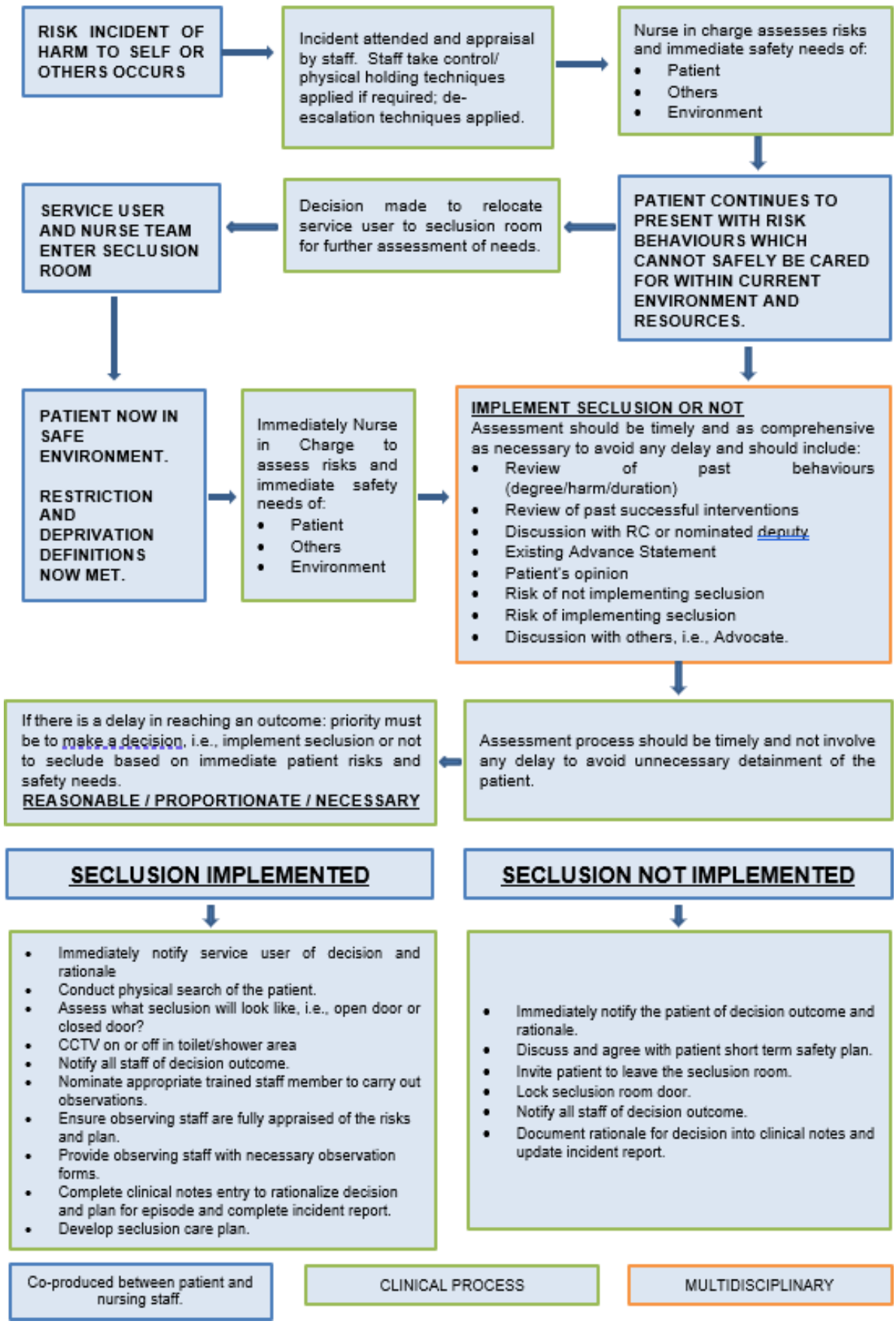
Lavelle, M., Stewart, D., James, K., Richardson, M., Renwick, L., Brennan, G. & Bowers,
L. 2016, “Predictors of effective de-escalation in acute inpatient psychiatric settings”, *Journal of Clinical Nursing,* vol. 25, no. 15-16, pp. 2180-2188.

National Institute for Health and Clinical Excellence (NICE, 2005): Clinical Guideline 25; the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments.

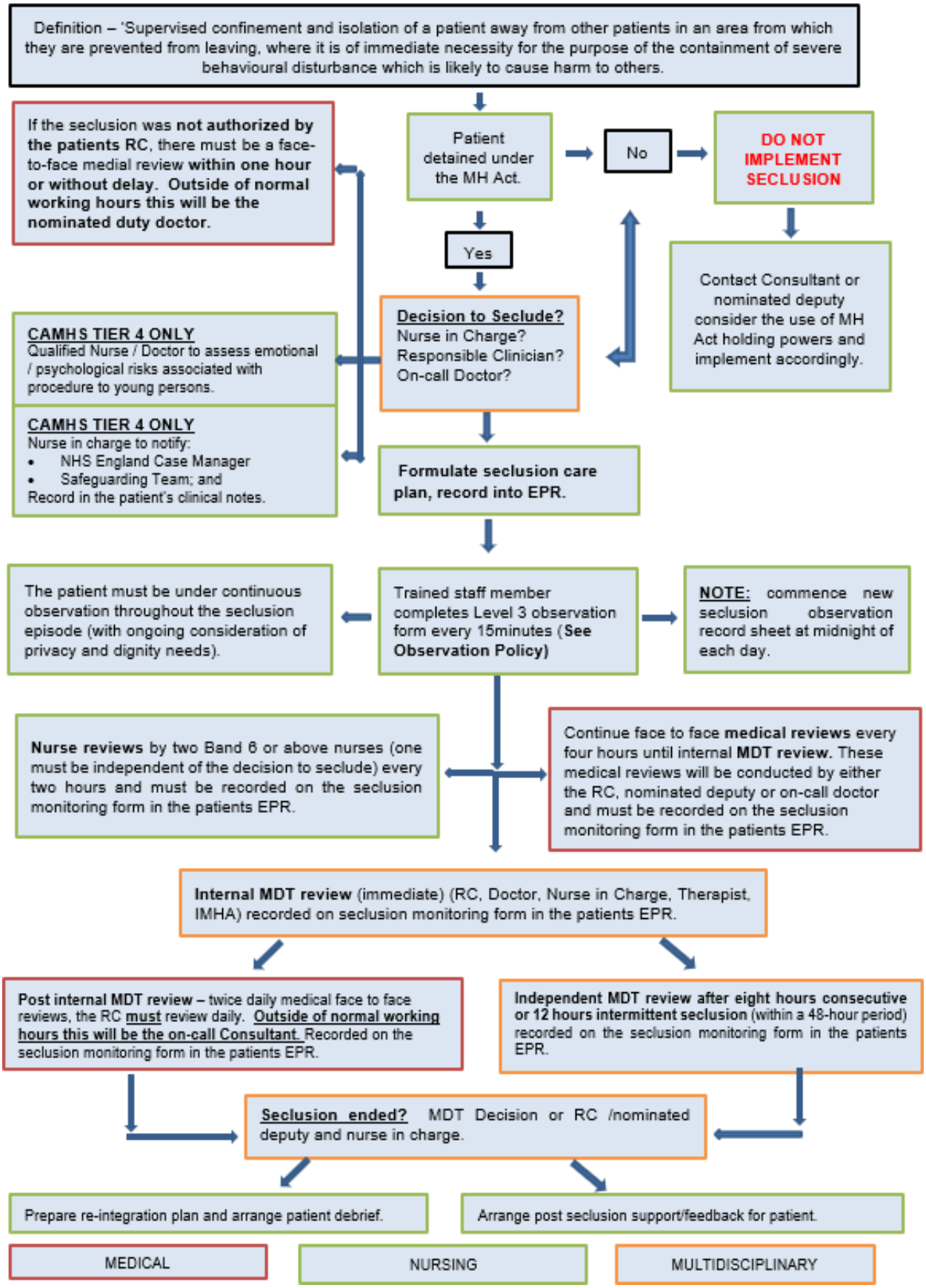
National Institute for Health and Care Excellence (2015): Violence and Aggression: short term management in mental health, health and community settings.

Royal College of Nursing (2013): Draft guidance on the minimisation of and alternatives to restrictive practices in health and adult social care, and special schools.

Flowchart – Assessment for Seclusion Process: Appendix 1

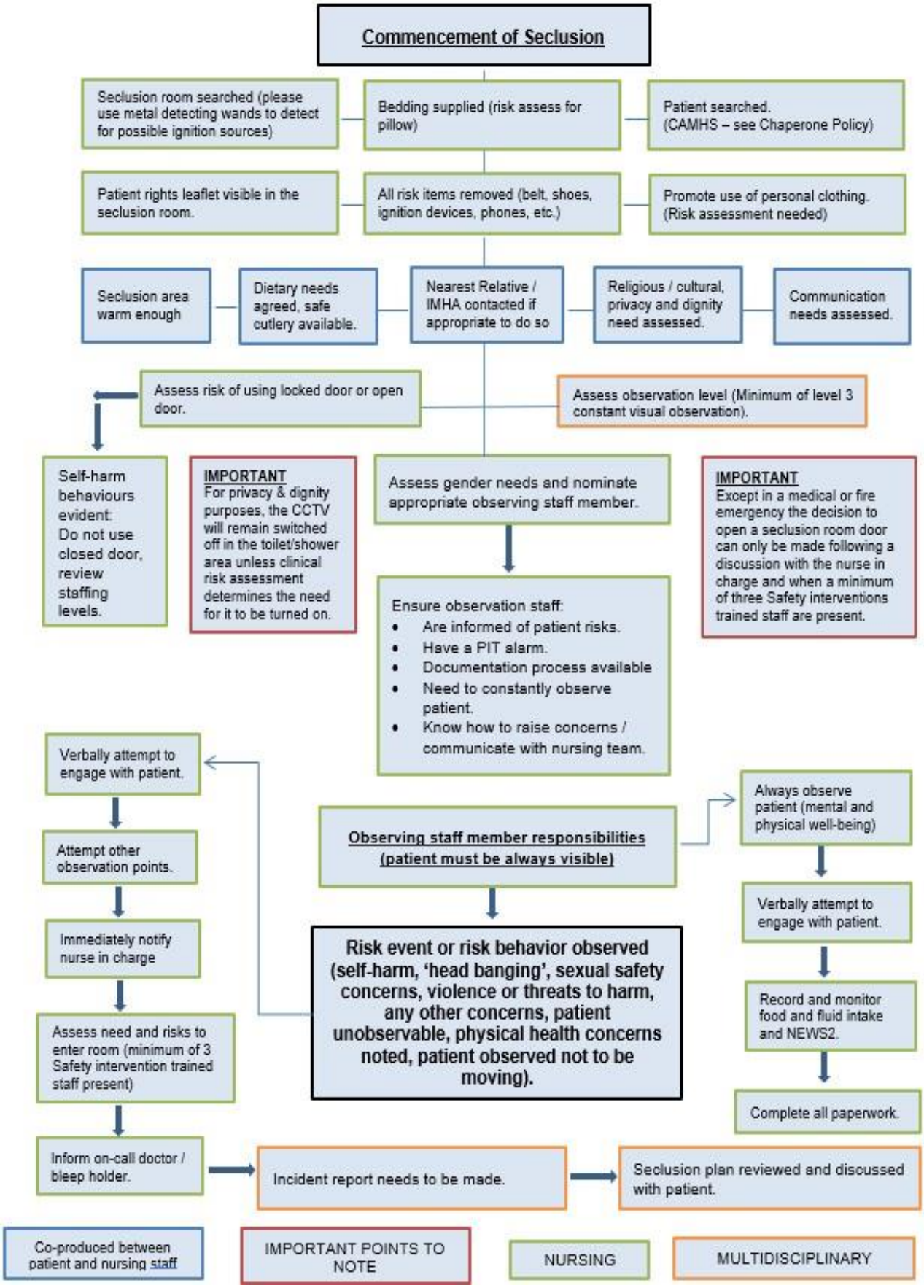


Flowchart – Seclusion initiation process-Adults and Young People Appendix 2

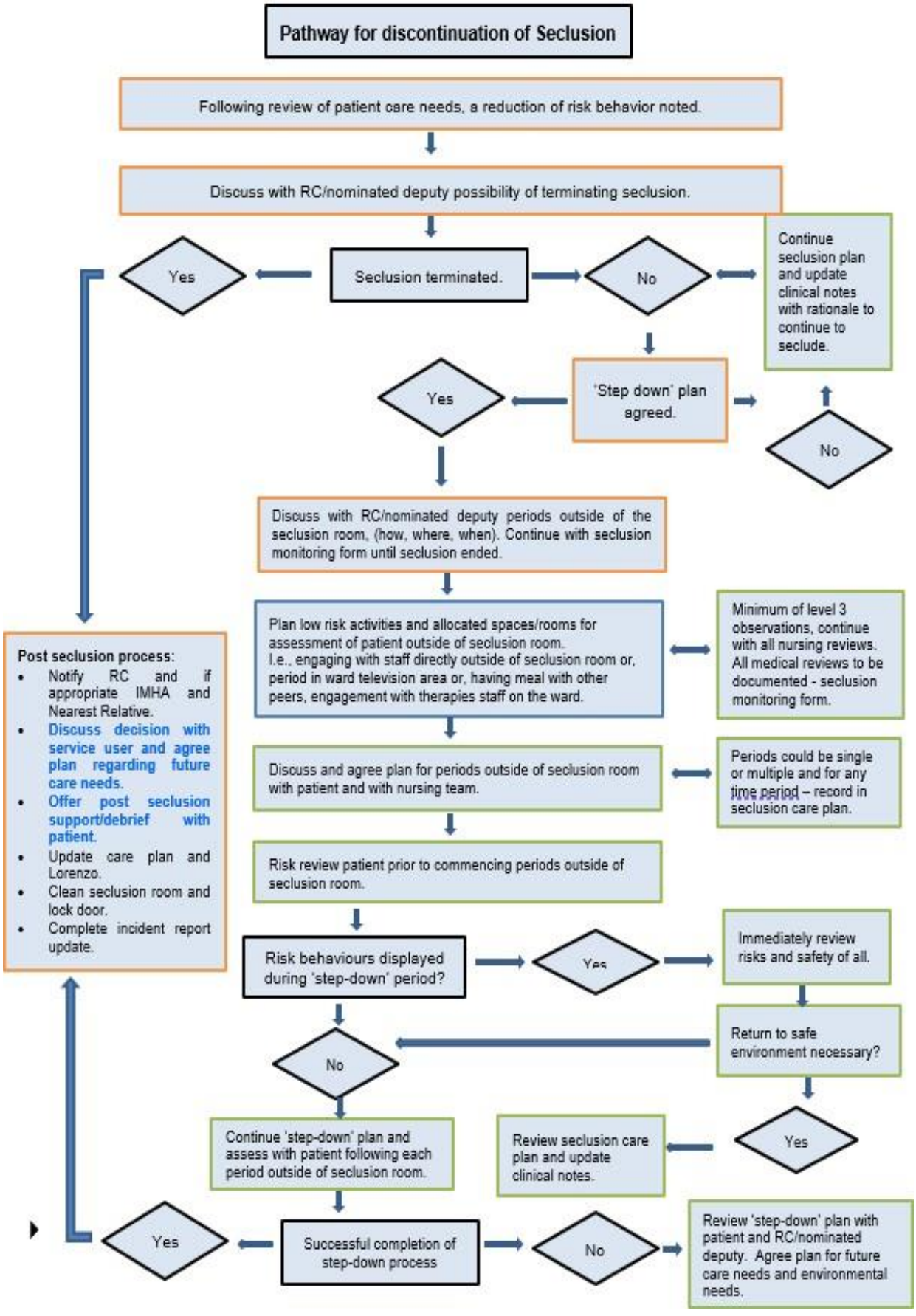


Flowchart - Seclusion Procedure

Appendix 3

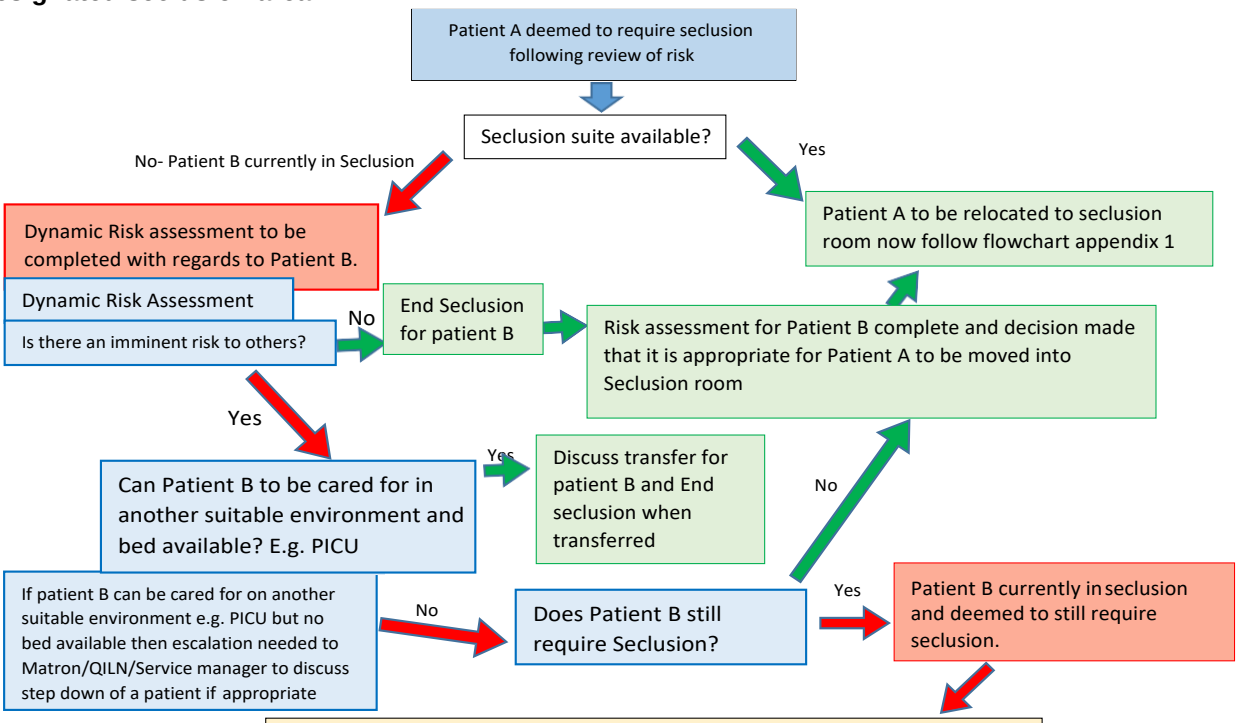


Flowchart – Discontinuation of Seclusion / 'step-down' process Appendix 4



Appendix 5

Flowchart- Temporary Unavailability of Seclusion Suite or Emergency use of a non-designated seclusion area



Discussion needed to ascertain risks of both patients and decisions to be made.

In normal working hours

- MDT decision/meeting to be convened if appropriate including ward Doctor/Consultant
- Nurse in charge to contact Matron/QILN/Service manager.
- Discussion with Reducing Restrictive practices Lead if available
- Escalation to Director of Nursing, AHP and Quality (or nominated deputy) to be contacted if needed.

To discuss

- How patients should be cared for to keep risks to a minimum.
- Appropriate place to use as non-approved room to confine patient.
- Need for escalation to find more appropriate environment for patient. E.g. external PICU.
- Decide where to care for each individual patient requiring seclusion

Out of hours

- Nurse in charge to contact site manager
- Contact On call Doctor/On call Consultant to discuss appropriate management plan
- Site manager to contact silver on call
- Silver on call to contact gold on call

To discuss

- How patients should be cared for to keep risks to a minimum.
- Appropriate place to use as non-approved room to confine patient.
- Need for escalation to find more appropriate environment for patient. E.g. external PICU.
- Decide where to care for each individual patient requiring seclusion

If the use of a non-approved room to confine a patient is deemed appropriate and necessary. *This should only occur as an emergency measure, be reasonable and proportionate to the risk and for the minimum time necessary*

Proximity should be considered to ensure safe transfer. Transfer to PICU if appropriate as a lower stimulus environment.

Environmental risk Assessment of the environment used as non approved room for seclusion to be with completed e.g. ligature points/blind spots and appropriate action taken

KEY POINTS TO REMEMBER

- ☐ The use of enhanced observation levels (minimum level 3) and increased staffing levels must be part of the measures used to maintain safety of all concerned.
- ☐ All reasonable efforts must be made to transfer patient to a safer environment at the earliest opportunity.
- ☐ The MHA code of practice/Trust policy principles of seclusion regarding nursing and medical reviews must be applied.
- ☐ **THE USE OF A NON-APPROVED ROOM TO CONFINE A PATIENT IS ONLY TO BE USED IN AN EMERGENCY AND FOR THE SHORTEST PERIOD OF TIME AS THIS DEPARTS FROM THE GUIDANCE IN THE MHA CODE OF PRACTICE**

SECLUSION OBSERVATION RECORD SHEET – 15 MINUTE CHECK

APPENDIX 6

(The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end)

Level 3 Constant Visual	CCTV / Privacy:		Date:		Time:	
Full Name:		NHS No.				
What items has the patient taken into the seclusion room?						
Following to be considered at each 15 minute review						
Your assessment - The record made should include: •Diet and Fluids taken: (see chart). • Physical Health presentation • Physical description / ABCDE • the patient's appearance • what they are doing and saying • their mood • their level of awareness • any evidence of physical ill health especially following administration of rapid tranquilisation with regard to their breathing, pallor or cyanosis.						
Time:		Observed behaviour:	Time:		Observed behaviour:	
Time:		Observed behaviour:	Time:		Observed behaviour:	
Time:		Observed behaviour:	Time:		Observed behaviour:	
Time:		Observed behaviour:	Time:		Observed behaviour:	
			Two-Hourly Recommendation	Seclusion to continue		Seclusion to end	

Patient's condition - Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

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SECLUSION OBSERVATION RECORD SHEET – 15 MINUTE CHECK

(The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end)

Level 3 Constant Visual	CCTV / Privacy:		Date:		Time:	

Full Name:		NHS No.	

What items has the patient taken into the seclusion room?

Following to be considered at each 15 minute review

Your assessment - The record made should include: •Diet and Fluids taken: (see chart). • Physical Health presentation • Physical description / ABCDE • the patient's appearance • what they are doing and saying • their mood • their level of awareness • any evidence of physical ill health especially following administration of rapid tranquilisation with regard to their breathing, pallor or cyanosis.

Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:

Two-Hourly Recommendation	Seclusion to continue		Seclusion to end	

2

Patient's condition - Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

LONG TERM SEGREGATION (LTS) 1 HOURLY OBSERVATION RECORD SHEET

APPENDIX 7

(The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which LTS and to support subsequent approved clinician and MDT reviews)

Full Name:		NHS No.	
Date:			

The following information is to be considered and recorded as part of the 1 hourly review

Your assessment - The record made should include: •diet and fluids taken • physical health presentation • the patient's appearance • what they are doing and saying • their mood • their level of awareness, engagement with activities • any evidence of physical ill health especially following administration of rapid tranquilisation with regard to their breathing, pallor or cyanosis.

Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:

Patient's condition - Where a patient appears to be asleep, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

Flowchart - Long Term Segregation process
APPENDIX 8

Definition- Long Term Segregation (LTS)
LTS refers to a situation where, in order to reduce a sustained risk of harm posed by the service user 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 service user should not be allowed to mix freely with other service users on the ward or unit on a long- term basis.

Multi-disciplinary team meeting to discuss service user needs. Discussion regarding need to use LTS to keep the person safe.

Decision to use long term segregation procedure?

No

MDT to agree care plan based on least restrictive intervention necessary and proportionate to the level of risk presented by person.

Yes

Inform:
- ✓ Service user and/or advocate or nearest relative
- ✓ Safeguarding team

Complete:
- ✓ Initiation of LTS form
- ✓ Incident form (for initiation of LTS)
- ✓ Observation chart (patient must be on level 3 observations)
- ✓ LTS care plan with service user involvement if possible
- ✓ **Document in service users clinical notes regarding decision to use LTS.**

Inform service user and involve in care plan development

Reviews to be completed:
Every 24 hours: by an approved clinician (Doctor or medical officer/staff)
Weekly: MDT to include person's Responsible Clinician and IMHA/ Advocate
At least every 28 days: Independent review team which should consist of 1 senior clinician who is not involved with the case (e.g., Consultant psychiatrist, Nurse consultant) and two other review team members (from outside the service and who are independent to the case e.g. Reducing Restrictive Practice Lead, Patient and Organisational matron
, social worker, Psychologist or Quality Improvement Lead)
3-Monthly: Multi professional team from another trust to be determined by the Director of Nursing and Quality/ or other Executive Director of the Trust. **The review should include discussions with the patients IMHA (where available and appropriate) and Service commissioner.**
THROUGHOUT EACH REVIEW SERVICE USER AND SERVICE USER ADVOCATE/NEAREST RELATIVE TO BE INVOLVED AND INFORMED OF ANY DECISION

Following the end of LTS :
Complete an Incident report to report end of LTS

APPENDIX 9

Long Term Segregation Initiation Form

The purpose of this tool is to facilitate and document a review of the patient's current care arrangements in order to determine whether their care regime amounts to Long Term Segregation (LTS) and if so, to provide a review of the current care plans, and formulate any recommendations that may positively contribute to the care and treatment of the patient.

It is recognised that some individuals' clinical needs can only be appropriately met within an individual service. This care *may* not necessarily be considered as long term segregation as defined within the MHA Code of Practice (1983).

This process seeks to clearly differentiate these two different situations and ensure that all care is provided to patients in the least restrictive manner.

Long-term segregation is described in the MHA Code of Practice (2015) at paragraph 26.150 as follows;
"*Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement is that, if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time. Where consideration is being given to long-term segregation, wherever appropriate, the views of the person's family and carers should be elicited and taken into account. The multi-disciplinary review should include an IMHA in cases where a patient has one."*

Although the MHA CoP refers to the need to protect others from harm presented by the patient, in some cases, long term segregation will be necessary in the interests of the individual- for example, in circumstances where a patient is unable to tolerate the ward environment or interaction with others.

The MHa CoP asserts that it is permissible to manage such patients in a way that minimises their contact with the general ward population and makes the following key points, which are adopted by The Trust as standards expected for patients in LTS;

<u>Environment</u>
The environment should be the least restrictive possible and should be as homely and personalised as practicable, given the risks associated with the individual.

Areas to be used for LTS should be configured so as to provide as a minimum a bathroom, a bedroom and a lounge area. Access to secure outside areas should be enabled and the use of LTS should not deny the patient access to activities of interest and relevant to them.

However, as with seclusion, in order to be considered as a person in 'segregation' the individual need not be placed in specific, purpose-built facilities. Moreover, the circumstances in which that individual is being held or treated will define whether care amounts to

segregation. This may mean that a person's bedroom becomes an environment in which Long Term Segregation takes place, if deemed appropriate by the multi-disciplinary team. This would not normally be recommended but may be more suitable than the removal of an individual to a different area or building, if the segregation is expected to be for a short period and their presentation allows it.

It is key that the environment used **must** have access to toilet and hygiene facilities must be safe and provide privacy from other patients to protect the individual's dignity.

Long Term Segregation Initiation Form

Patient's Name:		**Ward:**			
NHS number:		**Incident Report number:**			
Responsible Clinician:					
Long-term Segregation commenced:		**Date:**		**Time:**	
Date and Time of MDT meeting to agree LTS and who attended:					
Date:		**Time:**			
Name		**Position**			
Assessment: (to include Mental state, Risks and Physical health: (include record of any physical monitoring)					
Agreed summary:					
Rationale for decision:					
If Long-term Segregation is to continue state details of next review: (28 days from initiation)					
Form completed by:					
Name		Signature		Designation	
Date:		Time:			

APPENDIX 10

Long term Segregation Review Form

Use of the Checklist

To use this checklist please review each question and enter all relevant information. This should be by a combination of patient interview, review of case notes and multi-disciplinary discussion.

Review of Long-term Segregation

Please indicate which review:	**Weekly MDT**	
	Monthly Independent	
	3 Monthly Review	

Patient's Name:		**Ward:**			
NHS number:		**Responsible Clinician:**			
Long-term Segregation commenced:		Date:		Time:	
Date and Time of MDT Review and who attended:					
Date:		**Time:**		**Review Number:**	

Name	**Position**

ASSESSMENT (to include Mental state, Risks and Physical health: (include record of any physical monitoring)

Agreed summary:

Long-term Segregation to continue? Yes ☐ No ☐					
Rationale for decision:					
If Long-term Segregation is to continue state details of next review:					
Form completed by:					
Name		Signature		Designation	
Date:		Time:			

1.	Is there evidence that the patient's treatment plan clearly states the reasons why long-term segregation is required?
2.	Is there evidence that the way that the patient's situation is reviewed by the MDT reflects the specific nature of their management plan?
3.	List current medication?
4.	Is there evidence of who was consulted regarding current care arrangements?
5.	What is the history of aggression/restraint incidents?
6.	Does the patient express the wish to live or be elsewhere or integrate with others?
7.	Does the patient's behaviour suggest they wish to remain or leave the area? If not, has the capacity of the patient to make this decision been answered and where relevant the best interest checklist utilised.
8.	The purpose of the hospital review is to determine whether the ongoing risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their general health and welfare.

9.	Review teams discussion with the patient's IMHA (if appropriate).
10.	Where successive MDT reviews determine that segregation continues to be required, is there evidence of more information being available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner?
11.	The decision to end long-term segregation should be taken by the MDT (including consultation with the patient's IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient's presentation during close monitoring of the patient in the company of others.
12.	Any additional comments:
13.	Outcome:
14.	Recommendation(s) of the panel:
15.	If long term segregation continues - date of next internal hospital review will be due on:

Signature	
Name:	Signature:

APPENDIX 11

Long Term Segregation Three Month Review Report by External Hospital

Patient's Name:		**Ward:**			
NHS number:		**Incident Report number:**			
Responsible Clinician:					
Long-term Segregation commenced:		**Date:**		**Time:**	
Date and Time of External Review meeting and who attended:					
Date:		**Time:**			
Name		**Position**			

1.	Is there evidence that the patient's treatment plan clearly states the reasons why long-term segregation is required?
2.	Is there evidence that the way that the patient's situation is reviewed by the MDT reflects the specific nature of their management plan?
3.	The purpose of the three monthly external hospital review is to determine whether the ongoing risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their general health and welfare.

4.	Review teams discussion with the patient's IMHA (if appropriate).
5.	Review teams discussion with commissioner.
6.	Where successive MDT reviews determine that segregation continues to be required, is there evidence of more information being available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner?
7.	The decision to end long-term segregation should be taken by the MDT (including consultation with the patient's IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient's presentation during close monitoring of the patient in the company of others.
8.	Any additional comments:
9.	Summary of findings:
10.	If long term segregation continues - date of next external hospital review will be due on:
	Signature and Designation